IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

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STACIE RAY, BASIL ARGENTO, JANE DOE, AND ASHLEY BREDA,

Plaintiffs,

vs. Civil Action No. 2:18-CV-00272-MHW-CMV

AMY ACTON, IN HER OFFICIAL CAPACITY AS DIRECTOR OF THE OHIO DEPARTMENT OF HEALTH, et al.,

Defendants.

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Deposition of
RYAN GORTON, M.D.

October 8, 2019
10:15 a.m.
Taken at:
Calfee Halter & Griswold, LLP
41 South High Street, Suite 1200
Columbus, Ohio

Kimberly A. Kaz, RPR, Notary Public

APPEARANCES:

On behalf of the Plaintiffs:

American Civil Liberties Union of Ohio Foundation, by
ELIZABETH BONHAM, ESQ.
4506 Chester Avenue
Cleveland, Ohio 44103
(216) 472-2220
ebonham@acluohio.org

Lambda Legal, by
KARA N. INGELHART, ESQ.
105 West Adams Street, Suite 2600
Chicago, Illinois 60603
(312) 663-4413
kingelhart@lambdalegal.org

On behalf of the Defendants:

Calfee Halter & Griswold, LLP, by
JAKE BLAKE, ESQ.
41 South High Street, Suite 1200
Columbus, Ohio 43215
(614) 621-7789
jblake@calfee.com

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RYAN GORTON, M.D., of lawful age, called for examination, as provided by the Federal Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF RYAN GORTON, M.D.

BY MR. BLAKE:

Q. Please state and spell your name for the record.

A. Ryan Nicholas Gorton. It's R-y-a-n N-i-c-h-o-l-a-s G-o-r-t-o-n.

Q. And are you here to testify regarding an expert opinion that you rendered in the case of Stacie Ray, et al., versus the Director of the Ohio Department of Health, et al.?

A. I am.

Q. What are the areas of expertise in which you are qualified to give expert testimony?

A. Transgender health care.

Q. Is that all?

A. I'm also an emergency medicine physician, but I don't think this case has to do with that, so...

Q. So you -- you feel as if you're qualified as an expert in two areas, transgender health care and emergency medicine, but that as it relates to this case, only the transgender health care part is relevant; is that accurate?

A. Yes.

Q. By "transgender health care," what do you mean?

A. The health care specific to transgender patients, which is usually divided into medical care, mental health care and surgical care as well as the primary care services that they need that are unrelated to that.

Q. Okay. I assume you've been deposed a number of times, so I'm not going to spend a bunch of time going through sort of ground rules. You seem like you know how to take a deposition. I will just say that, you know, if at any time you need a break, as long as there's not a question pending, just let me know, and we'll take a break.

Also, if you don't understand a question, you know, you can let me know. If

you answer a question, I'll assume you understood the question; is that fair?

A. Yes.

Q. Okay. Can you start with just describing briefly your -- your education and undergraduate?

A. I got a Bachelor of Science in biochemistry from North Carolina State University, and then I got my medical degree from the University of North Carolina Chapel Hill School of Medicine.

Q. And after obtaining your medical degree from Chapel Hill, did you enter a residency program?

A. I did.

Q. And where did you conduct your residency?

A. Brooklyn, New York at Kings County Hospital.

Q. And was that a general residency or, like, a specialty or --

A. It was emergency medicine.

Q. And how long was that residency?

A. Four years.

Q. And what is emergency medicine?

A. The saying goes any person, any problem, any time. So the provision of, essentially, all emergency care that people might present to a hospital with.

Q. So is this, like, the emergency room doctor when you walk in the emergency room, you're going to be seen by a physician at some point? Is that what -- is that what you do or what you trained as a resident to do?

A. Correct.

Q. After your residency, did you immediately begin practicing somewhere, did you go to a fellowship, or what did you do?

A. I didn't do a fellowship, I started working at Saint Tammany Parish Hospital in Covington, Louisiana.

Q. What year was that?

A. 2002.

Q. And how long were you in Covington?

A. About three years.

Q. Where did you go after that?

A. I moved to California and started practicing at Sutter Davis Hospital in Davis, California and Lyon-Martin Health Services, which, at the time was Lyon-Martin Women's

Health Services in San Francisco.

Q. Is Davis, California near San Francisco?

A. It's closer to Sacramento.

Q. So you would commute between the two?

A. Yes. I live in Davis and would go to San Francisco -- drive to San Francisco to work at Lyon-Martin.

Q. And you started that in 2005?

A. Yes.

Q. Do you still work at any of those places or --

A. I still work at both of those places.

Q. Okay. Any other employment or -- yeah. Any other employment since you started working at Sutter Davis and Lyon-Martin?

A. No.

Q. Other than your MD and your residency in emergency medicine, have you obtained any other medical certifications or licenses or specialties?

A. I am board certified in emergency medicine and I am also certified with WPATH in

their GEI program, which is something that I've added to my resume since I provided you one because I recently found out I passed the test.

Q. Okay. So let's talk about the board certification in emergency medicine. Is that -- is that a license that you're required to maintain in order to practice medicine?

A. In order to practice medicine, no, but a lot of emergency departments require that to be able to be employed there.

Q. Are there, like, classes you have to take or coursework you have to complete within a year or two-year period in order to maintain that certification?

A. You have to do a certain amount of continuing medical education, and ABEM, the American Board of Emergency Medicine, has this program they call ConCert, which is continuous certification, where you have to take a test. I can't tell you the exact number, but it's -- I think it's, like, seven out of ten years between your test -- retesting for board certification, and then every tenth year, you have to sit for an exam.

Q. And who -- who, then, approves the

certification for the -- for the doctors that are board certified?

A. I'm not sure I understand the question.

Q. Well, what organization is in charge of issuing the licenses or the certifications?

A. The board certification, like I said, is ABEM, the American Board of Emergency Medicine.

Q. Okay. That's the actual entity that administers the curriculum or the requirements in order to get the certification?

A. Correct.

Q. Okay. And who is -- what is ABEM comprised of or who are ABEM's members?

A. Emergency medicine physicians in the U.S.

Q. What does it take to be -- well, does ABEM have, like, a board or panel? I mean, who sets the criteria?

A. I am honestly not certain of how they set the criteria, but they set the criteria for what is an emergency medicine residency and what it must contain, and they

also set the criteria that you have to have completed emergency medicine residency before you sit for the boards, but I don't know how they decide what questions are on the exam or, like, specifics like that.

Q. But it's -- in any event, it's other doctors who are -- this certification and who have received training as emergency medicine physicians, right?

A. Sure.

Q. Okay. What is the WPATH GEI program?

A. WPATH is the World Professional Association for Transgender Health, which is essentially the professional organization for, generally, medical and mental health providers who provide care for transgender patients. And "GEI" stands for Global Education Initiative. And it's not like a board certification, but it is similar in that you have to have certain qualifications and a certain set of classes that you have to complete and then you sit for an exam. And so it's an indication that WPATH thinks you have at least basic competency in providing transgender care.

Q. Who sets the coursework or exams or who creates the exams for the GEI program?

A. Medical and mental health providers within WPATH. And I should add that I was actually allowed to grandfather in because of extensive experience since this is a relatively new program, so because of that, I was allowed just to sit for the exam, although I did actually sit in on the first course that they require for people who don't have an extensive amount of experience to become certified.

Q. But you weren't required to take the full coursework before sitting for the exam, right?

A. No, because of previous experience. And that's pretty typical for most of these things. Like, the American Board of Emergency Medicine originally allowed physicians who hadn't completed a residency but had extensive experience in emergency medicine just to sit for the exam.

Q. And you said you just recently received word that you passed the GEI exam, right?

A. Yes.

Q. And when did you sit for that exam?
A. There was a period of time you could do it, and I think I did it almost near the end of that, and I think it was -- it was sometime in September because I remember doing it at the USPATH conference.
Q. So they offered the exam only certain times during the year?
A. There was a window during which you could take the exam. I don't know specific times that --
Q. What was that window?
A. It was at least a few weeks, but it might have been longer than that. I kind of just wrote the deadline down in my schedule and took it before the deadline.
Q. And that was, you think, in September?
A. I know it was in September. I couldn't tell you the exact date.
Q. This year?
A. This year, yes.
Q. Where did you go to take the exam?
A. It's an online exam, so I did it, actually, in my hotel room.

Q. So you took the exam from your hotel room while you were attending a WPATH conference or something?

A. USPATH.

Q. USPATH.

How long did the exam take you to complete?

A. Probably four hours total, but I broke it up.

Q. Do you recall approximately how many questions are on it?

A. I don't recall the exact number, but I would say it's probably somewhere between 20 and 60.

Q. What about your exam for board certification in emergency medicine, how -- where did you take that exam?

A. The initial -- or the first time when you get board certified, there are actually two exams. There's a written one, and I took that somewhere in Texas, maybe Dallas/Fort Worth.

Q. You had to go someplace where they were offering the exam?

A. Yes. And then I took the oral

exam. It was somewhere in the midwest, maybe Chicago. I'm not sure.

Q. Did you go somewhere else to meet with folks and be examined orally?

A. Exactly, for the oral exam. And then my one recertification, I just did at the testing center in California.

Q. Again, some other place where they say here's a location you can go to recertify, right?

A. It used to be they would have, essentially, a pencil-and-paper exam that everybody took and they -- there were a few places in the U.S. at certain times you could take it, but now it's an electronic exam, so you just find the closest testing center to you, and that's both for people initially certifying now for the written exam and for anybody who's recertifying.

Q. Okay. So the process now, if you were to be coming out of med school at this point, you would take the written exam at one of these testing locations, remote testing locations around the country, and then you'd still have to go for your oral exam somewhere,

right?

A. Correct.

Q. Is it always in the midwest, or that's just when it was there?

A. I have no idea.

Q. Okay. Do you recall how many questions were on the written exam?

A. Not even close. No idea.

Q. I mean, is it, like, 100, 200?

A. It took me a couple of hours to complete the recertification exam, so maybe a hundred. That's a total guess, though. It wasn't short, but it wasn't a two-day exam.

Q. How long did you spend preparing for the ABME [sic] exam?

A. ABEM. And do you mean the initial certification or recertification?

Q. The initial certification.

A. Honestly, not that much 'cause I was fresh out of residency. Maybe ten, 20 hours.

Q. And how long did you spend preparing for the GEI exam?

A. Maybe a couple of hours, which was mostly just reviewing the WPATH standard of

care.

Q. All right. You mentioned that you didn't have to take any coursework prior to sitting for the GEI program, and that was based on your experience with transgender medicine; is that right?

A. Correct.

Q. So can you briefly describe what that experience has been since seems like about 2005?

A. I've been continuously working at Lyon-Martin with a moderately large panel of trans patients, but then, also, I teach students and residents, I do presentations, I work on the -- on TransLine, the national clinical consultation service, and I also keep up to date with the trans literature, the trans medical literature.

Q. So do you have trans patients at Lyon-Martin and Sutter Davis?

A. In emergency medicine, you don't have patients that you follow longitudinally, but, yes, I've seen a number of trans patients at Sutter Davis.

Q. Is your work at Lyon-Martin

emergency medicine as well?

A. No. It's primary care, so I see patients repeatedly over a course of time.

Q. Okay. So primary care, that's at Lyon-Martin, and then you're still maintaining your emergency medicine practice at Sutter Davis; is that accurate?

A. Correct.

Q. And so you have seen trans patients at Sutter Davis, but that's just because you take whomever's having emergency, and some of those folks happen to be trans, right?

A. Correct.

Q. But as a primary care physician at Lyon-Martin, trans patients come in and you treat them as their primary care physician, right?

A. Correct.

Q. Okay. You said it used to be known as women's health, Lyon-Martin Women's Health. It's no longer called that?

A. Lyon-Martin was originally a for us, by us clinic for lesbian and bisexual women, and it was either late '70s or early '80s that it was founded. And then in the

'90s, they started providing transgender care, and somewhere around 2007 or '8 or maybe even 2009, the clinic changed the name from Lyon-Martin Women's Health Services to Lyon-Martin Health Services, recognizing that we have a lot of patients who weren't women, they were transgender men and transgender women.

Q. Okay. So you provide care -- that was going to be my next question. Although Lyon-Martin was originally a women's health clinic, when it comes to the transgendered patient, you treat both transgendered men and transgendered women?

A. Correct.

Q. Got it.

So it dropped -- at this point, has dropped the "women's health" part of their name?

A. To be more inclusive, yes.

Q. You say you teach students and residents. Is Lyon-Martin a teaching hospital?

A. It's not a hospital, it's a clinic, but, yes, we do have students and residents all the time.

Q. You get them on, like, some sort of rotation or something?

A. Yes.

Q. Okay. As part of their residency, some of those folks come out to Lyon-Martin and work?

A. Yes, although it's more students than residents.

Q. Okay. And when you mean students, you mean, like, medical students?

A. Medical students, nurse practitioner students, physician's assistant students.

Q. Okay. And at Sutter Davis, is that a teaching hospital?

A. It has a family practice residency, but that's it.

Q. Okay. And you're not involved in that?

A. I am because the family practice residents, as part of their residency, do do rotations in the emergency department, but it's an occasional thing.

Q. It's a very small part of what you do?

A. Correct.
Q. When you were referencing your experience with trans medicine and teaching students and residents, you were talking about what you do at Lyon-Martin, right?
A. Yes. But I actually do, like, once a year, maybe once every two years, 'cause it's a three-year residency, do talk on trans medicine for the family practice residents at Sutter Davis just 'cause I have that expertise and they ask me to do it.
Q. So the Sutter Davis residents, in that family practice, as part of their curriculum, at some point during their stint there, they ask you to come and talk to them about some of these transgender issues?
A. Correct.
Q. What is TransLine?
A. It's a national clinical consultation service that essentially provides a way for health care providers to ask questions of health care providers who are more experienced in transgender care about their patients. So if you have, say, a family practice doctor in rural Iowa who's never had a

trans patient and they have one and they have questions, they can call -- or, not call, they can submit an electronic ticket, and most of the time, they're answered by e-mail. Occasionally, we call people and have a conversation.

Q. Okay. So this is, like, a doctor-to-doctor, medical provider-to-medical provider interface for folks who don't have a lot of experience with this issue to reach out to individuals who have experience with transgender issues, right?

A. Mostly. Though, occasionally, we do get some very experienced providers who ask very tough questions that takes a while to answer. But mostly it's providers with maybe not completely inexperience, but they have a patient who has something they've never seen before. They may have ten trans patients, but this is just a complex case.

Q. Right. It's a resource that medical providers have available to them?

A. Correct.

Q. And what's your involvement with TransLine?

A. I'm the lead clinician and I also answer questions. It's a rotation. There's a number of different LGBT health care centers that staff it, and so I do our portion of answering questions, and then I also am a resource for some of the other providers. So a provider who's answering questions might not be able to answer something, so it gets bounced to me.

Q. Okay. So you're like a resource for the resource sometimes; is that fair?

A. Sometimes. Most of the time, it's -- they don't have to ask anything. And, I mean, honestly, I sometimes have to seek outside assistance if it's really super complicated.

Q. From other people within the TransLine network?

A. Yes, or occasionally consultants that I know.

Q. Okay. What is a lead clinician, what's the significance of that title?

A. I think one is that I'm the second line if there's a question that's not readily answered, but also, I work with JM Jaffe,

that's J-a-f-f-e, and JM is the -- I'm not sure what their title is. I think it's manager, but they're the one who sets the schedules and sends people the tickets to answer and sort of runs TransLine, and they and I go over data. Actually, at USPATH, we presented one paper about TransLine unitization, so some meta level stuff.

Q. So JM Jaffe, that's sort of the administrative arm of TransLine, and you do some coordination with them?

A. Correct.

Q. Okay. Approximately how many times have you been an expert witness in the last ten years?

A. Well, what do you define as expert witness? Like, what part of it?

Q. Sure. Any time that you've been retained by an attorney or party to serve as an expert witness, whether or not you rendered an opinion or sat for a deposition or examined at trial.

A. Gotcha. So probably eight to ten times in the past ten years. It could be a little more. Maybe call it eight to 12.

Q. What types of matters have -- have you been retained in as an expert witness those eight to 12 times?

A. They're all transgender cases. I haven't been an emergency medicine expert witness.

Q. Have you ever been a party to a lawsuit?

A. Have I ever been sued?

Q. Yes.

A. Yes.

Q. Or sued, or you're a plaintiff, right, you're the one --

A. Never been a plaintiff, but I've been sued.

Q. And the times -- is there more than once?

A. Yes.

Q. Okay. How many times?

A. Five, I think.

Q. Were those -- I'm assuming those were all related to your medical practice?

A. Yes.

Q. Were those medical malpractice cases?

A. Yes.
Q. You were a defendant?
A. Yes.
Q. Were any of those related to your work as a provider of transgender medicine?
A. One.
Q. When was that case?
A. Couple of years ago.
Q. So that was a patient that you were seeing at Lyon?
A. At Lyon-Martin, yes.
Q. What were the allegations in that matter?
MS. INGELHART: Objection. To the extent you can answer without waiving privilege, you can answer.
THE WITNESS: So it was a patient who sued the clinic and me for being referred for sex reassignment surgery, though I don't believe they sued the surgeon. I was dropped from the case, but I believe the clinic settled.
Q. Did the plaintiff claim that they should not have been referred for sex reassignment surgery?

A. I think there may be a nondisclosure agreement, I apologize, that I'm not entirely sure, but I think there was, so I'm not sure how much I can actually say.

Q. Do you recall the name of the plaintiff or the name of the case?

MS. INGELHART: Same objection as before. You can answer.

THE WITNESS: Yes. I don't know if it violates HIPAA to say that. I mean, I'm just not sure.

Q. Yeah. Well, the case should be public record. I mean, it was filed. It was a complaint.

A. Okay.

Q. And, again, if you're under an NDA which says the only thing you can say if asked about this thing is I was dropped from the case and I believe the hospital settled, the clinic settled, so be it. But, you know, the name of the -- the name of the case is public record.

MS. INGELHART: Objection. Unless it's a Jane Doe.

MR. BLAKE: That's fine.

THE WITNESS: It wasn't a Jane Doe.

It was -- the last name was Page, P-a-g-e, and I'm not sure what name the first name they used, but it was -- "J" was the initial.

Q. But it would be Page versus --

A. Lyon-Martin and me.

Q. Yeah. And you said a couple years ago, right?

A. Yeah. It feels like a couple of years ago.

Q. Okay. So maybe filed in 2016, '17 or '18?

A. I don't think it would have been as late as '18.

Q. Okay. So these eight to 12 transgendered cases that you've been an expert witness is, what, generally, are the issues involved?

A. I would say at least half are transgender patients in prison who are suing to get medically necessary care.

Q. And what is that? That's some amount of, like, reassignment, either it's hormone treatment or a medical intervention of some other kind; is that accurate?

A. And social transition issues.

Q. Okay. Do you consider social transition part of medical treatment?

A. Yes.

Q. And was the issue that the prison was not providing the medically necessary treatment and it was your expert testimony that this is medically necessary and so it needs to be provided?

A. Not all those cases I testified in, but, yes, in the cases where I did.

Q. That was your opinion in the cases where you testified, and had you testified, that would have been your opinion?

A. I can't tell you what my opinion would have been in the other cases because I never got there, so...

Q. Have you ever been retained in a prison case, transgendered prison case where you didn't find that the treatment was medically necessary?

A. Like I said, I didn't render an opinion in a couple of those, so I can't tell you what my opinion would have been, but in the cases where I did render an opinion, in all those, it was pretty obvious that the person

needed medically necessary care.

Q. All right. So the other half were not prison cases. I assume they fall into probably several categories. Can you tell me what those categories are?

A. Sure. So this case is one of them.

Q. This is an identity document case?

A. Correct.

Q. Any other identity document cases besides this one?

A. One other.

Q. Okay. What other types of cases?

A. There was one case where I -- or where the defendant had -- was a physician who had treated a transgender patient who then committed suicide, and the state was trying to take away his license to practice.

Q. The patient committed suicide?

A. Correct.

Q. Okay. Which party in that case retained you?

A. The physicians.

Q. Okay.

A. Not the state.

Q. So this was the medical board of

whatever state this occurred in was trying to take away the physician's license, right?

A. Correct.

Q. And were you retained as an expert in that case to opine on what the standard of care was for that physician when they were rendering these medical services to the transgendered patient?

A. Correct.

Q. And what did you conclude in that case?

A. That testosterone treatment for transgender men is recognized and appropriate, and while providing treatment for transgender patients diminishes their suicide risk, it doesn't eliminate it, so I don't think providing testosterone was the wrong thing to do.

Q. Okay. Any other transgendered cases?

A. I may have signed on to a couple of Amicus briefs. Gavin Graham, I think, was one.

Q. That's a bathroom case, right?

A. I believe so. Well, facilities.

Q. Facilities case. Yeah, there was

locker room or something, right?

A. Correct.

Q. Okay. Any other that you -- any others that you can recall?

A. In the last ten years -- oh, actually, yeah. Zucker V. Cruz in New York, which was sued on behalf of New York recipients of Medicaid because the state wasn't providing -- or wasn't paying for medically necessary treatment for transgender Medicaid recipients.

Q. I assume Gavin V. Grimm you signed on to an Amicus brief on the plaintiff's side, right?

A. Yes.

Q. And same goes for Zucker V. Cruz, you -- you were retained as an expert witness for the plaintiff suing the state to recognize that Medicaid should pay for these services, right?

A. Plaintiffs, yes. There's more than one plaintiff.

Q. Oh, plaintiffs. Sorry.

Okay. And the identity document case, obviously, you're an expert witness for

plaintiff, right?

A. In this case, yes.

Q. And then in the other identity document case, you were an expert witness for plaintiff, right?

A. Correct.

Q. Do you remember what type of identity document was an issue in that other identity document case?

A. Well, it's still ongoing. It's driver's license.

Q. Driver's license. What's the issue in that driver's license case?

A. That the state won't provide amended or correct driver's licenses to patients who are transgender.

Q. What state is that in?

A. Alabama. And I don't think it's a matter that they won't, it's -- they won't entirely, it's just that they have a surgical requirement.

Q. Before they change the driver's license?

A. Correct.

Q. Is this the only birth certificate

case you've been involved in?

A. I think so, yes.

Q. Other than the physician defendant that you referenced where you testified that the physician didn't violate the standard of care or at least you opine that the physician didn't violate the standard of care, have you represented defendants in any other matters?

A. Physician defendants, no.

Q. Any other -- any other defendant?

A. Not that I can remember.

Q. Okay. So all the other times you've been retained as an expert witness, it's been on behalf of plaintiff or plaintiffs?

A. I think so. I'm not a lawyer, but I think that's the case, yes.

Q. Have you ever been retained as an expert witness for any state, government or agency or anything like that?

A. I haven't been asked, so no.

Q. Okay.

MS. INGELHART: Excuse me. May we take a quick break?

MR. BLAKE: Sure.

(Recess taken.)

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(Thereupon, Deposition Exhibit 19, Expert Report, was marked for purposes of identification.)

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Q. You've just been handed what has been marked as Defendants' Exhibit 19. And this is a copy of your expert report. Do you recognize this document?

A. I do.

Q. We'll get to this in a little bit, but in the back, I've also attached Exhibits A and B to your report, which are your CV and bibliography. Do those appear to be true and accurate copies?

A. Again, I've added a couple of things to my CV, but for the most part, yes.

Q. All right. Turn to Paragraph 4 on the second page of the report. You listed a few cases where you've testified as an expert at trial or by deposition. You've listed Corbitt V. Taylor, Edmo V. Idaho Department of Corrections, Keohane V. Jones and Cruz V. Zucker. Do you see that?

A. I do.

Q. Are those -- those are the only cases you've testified as an expert witness in the last four years?

A. Yes, that got to the point of deposition or testimony.

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(Thereupon, Deposition Exhibit 20, Declaration, was marked for purposes of identification.)

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Q. Just handed you what's been marked as Defendants' 20. If you turn to the second page, it is an Eastern District of Wisconsin case, Ashton Whitaker V. Kenosha Unified School District. Do you see that?

A. I do.

Q. And it's a declaration that you've? -- of Dr. R. Nicholas Gorton, M.D. That's you, right?

A. Correct.

Q. And it looks like it's a 2016 case, and this declaration was filed on August 15th, 2016, right?

A. Yes.

Q. Is there a reason why this wasn't

included in Paragraph 4?

A. I don't think I did a deposition on this or testimony at trial, and also, I did forget about this, so...

Q. Okay. So no deposition or testimony at trial, but there was a declaration, right?

A. Yes.

Q. Okay. You can put that aside.

Corbitt V. Taylor, is that a case that we talked about already?

A. That's one of the ongoing ones, yes.

Q. Okay. Is that the driver's license case?

A. Correct.

Q. And Edmo V. Idaho Department of Corrections, I assume that's one of the prison cases?

A. Yes.

Q. Keohane V. Jones?

A. That was a prison case in Florida.

Q. Also a prison case.

And Cruz V. Zucker, you mentioned that one. That's the Medicaid case, right?

A. Correct.
Q. Is the driver's license case the only ongoing case or are some of these others still ongoing?
A. The other ones aren't ongoing.
Q. Okay. And what about Whitaker, Defendants' Exhibit 20, is that one ongoing?
A. I honestly don't even know.
Q. Okay. Have you ever served as an expert witness for Stacie Ray or any of the other plaintiffs?
A. No.
Q. Have you ever served as an expert witness for opposing counsel seated next to you?
A. For their organization or for these two people?
Q. For them individually.
A. No.
Q. Okay. Have you ever served as an expert witness for attorneys from Lambda Legal?
A. Yes.
Q. Okay. In what cases have you served as an expert witness for Lambda Legal?
A. Great question. Let me restate

that. I do work with Lambda Legal, and a lot of these cases have, like, four co-counsels, so I think one of them might have -- I can't tell you specifically, but I do work with Lambda Legal.

Q. So you think one or two times, you've been an expert witness for cases where Lambda Legal is involved?

A. I believe so, yeah.

Q. Do you know which cases?

A. I don't.

Q. Other than as an expert witness, do you work with or for Lambda Legal?

A. I've done a few, like -- like, I reviewed a couple of studies for them and gave them my opinion on it, but it wasn't for a specific case.

Q. So just some, like, very basic consulting work?

A. Exactly.

Q. But as far as you know, that wasn't in connection with any cases?

A. Not that I know of.

Q. Do you recall what studies they asked you to review?

A. The Hayes report was one that I can remember.
Q. Hayes report?
A. Yes, H-a-y-e-s.
Q. Any others?
A. That I can quote off the top of my head, no.
Q. What is the Hayes report?
A. Hayes is a private company that, for -- usually, clients that are large insurers or other health care payors, analyzes medical technologies or treatments, and this was their analysis of transgender health care. I can't tell you the exact title of the report, but it was something like that.
Q. Do you know why you were asked to review the Hayes report?
A. The original one that I reviewed for Lambda Legal, I think it was because it was being used by payors to deny care, and then also an updated version was utilized in Cruz V. Zucker, but that analysis, I didn't do with Lambda Legal, it was with the attorneys in Cruz V. Zucker.
Q. And so were you asked to criticize

or refute aspects of the Hayes report?

A. That came up in Cruz V. Zucker. There were a lot of things that they said -- or that Hayes said in the Hayes report that I think ran counter to the standard of medical treatment for trans patients, and so I had opinions based on that. The original Hayes report, they just sort of said tell us what you think about this, and I don't know if it was -- I think it was probably being used to deny care for patients, but I'm not exactly sure 'cause this was, like, more than ten years ago.

Q. Oh, it was a long time ago?

A. Yeah. It was, like, 2006 or '7, something like that.

Q. Pre-iPhone?

A. Exactly. Exactly.

Q. Dark ages.

I can probably guess, but what was your opinion about the Hayes report?

A. The original One?

Q. Yes.

A. Was horrible and plagiarized.

Q. The Hayes report was horrible and plagiarized?

A. Yeah. It had a tremendous amount of systematic bias, and I figured out by repeating their described search procedure that the articles that they said they found, they wouldn't have found that way, but those were the same articles that were found by another review that they cited, so...

Q. So they -- they cited -- they found one source that compiled a bunch of other sources, and you think that the Hayes report just basically -- well, you said plagiarized, but copied, right, copied that research?

A. I think they just used the articles that the other report used because, like I said, if you repeat their search strategy as described in the paper, you don't get two of the articles that they said they found with that search strategy, and there were also a couple of articles that they should have found with that search strategy that were published after the prior report was published, and so two plus two usually equals four.

Q. And how does -- how did that methodology of collecting resources undermine any of the opinions in the Hayes report?

A. It certainly makes you think about their other methodologies. So once you have the papers that you're going to review, you analyze them in a systematic way if you're going a systemic review. And, in addition, in the rest of the report, there was a systemic bias, so papers that showed positive results, they minimized and they also just completely misinterpreted a couple of other studies. It was not very well done.

Q. So the original Hayes report, in your opinion, exhibited systemic bias and/or misinterpreted several studies?

A. Yes.

Q. By the time you were hired as an expert in Cruz V. Zucker, had the Hayes report corrected what you understood to be errors?

A. Some of them, but not all of them, and there was still a tremendous amount of systemic bias.

Q. But you would agree, then, that systemic bias is something to be avoided if you're trying to create a valid study or report of transgendered issues or, really, any issue, medical issue, right?

A. You want to avoid all bias, but people are human beings, so it's never possible to be completely unbiased, but there are well-known ways to reduce or eliminate it.

Q. Such as what? How do you eliminate or avoid bias in a study?

A. So in something like the Hayes report where you are looking at a whole bunch of studies and doing a systemic review, blinding people to who the authors were, having multiple reviewers, also one thing that's really important is to list the authors of the paper and have the authors list their -- or things that might bias them like I'm paid by the drug company that manufactures the drug that we're talking about. And, for example, the Hayes report, no authors listed and no biases listed, though if you go to their website, most, if not all of their clients are health care payors, which is a pretty tremendous bias that should be declared, but wasn't. And you can't tell the bias of the individual authors because there were none listed.

Q. So at least, I mean, is that

blinding the authors, then?

A. No. Blinding the authors would be like showing you a paper and not knowing who wrote it so you can't be like, oh, well, I know Steve. He's not really good. And, also, too, having multiple people review the same article, so if I think it's positive in this way, you think it's positive in this way, but a third reviewer says, no, I think there's a limitation, then you -- you know, you come to consensus about what you think it ultimately is.

Q. So if the Hayes report didn't list their authors, how is that not -- how is that not blinding the authors?

A. No. I'm not -- I was giving two different examples.

Q. Okay. The problem with the Hayes report isn't the blinding problem, the problem with the Hayes report is that the potential conflicts of the authors weren't disclosed?

A. Well, there's many problems. And, for example, you can't tell a lot of what they did because they just don't say it in the paper like a normal systemic review would.

Q. Have you ever served as an expert witness for the ACLU?
A. Yes.
Q. Approximately how many times?
A. This case, the Alabama case, maybe they were co-counsel for Cruz V. Zucker. I'm not sure.
Q. Okay.
A. I know one lawyer that I worked with on Cruz V. Zucker is now an ACLU lawyer, but I don't know if he was at the time, so...
Q. A few times?
A. That's fair.
Q. And have you ever done any other non-expert witness consulting or work with the ACLU?
A. Probably because I may just get random e-mails from people saying what do you think about this, so I'm on a number of Rolodexes.
Q. So you think from time to time, you just receive -- people from the ACLU reach out and try to get your thoughts on one issue or another?
A. That's fair.

Q. Is it generally transgender related issues?

A. Yeah. That's --

Q. Exclusively?

A. I'm not sure about exclusively, but that's my area of expertise, so...

Q. There's no one sending you a question about free speech or something like that, right?

A. No.

Q. Okay. Have you ever served as an expert witness for attorneys with any other group like Lambda Legal or the ACLU?

A. Sylvia Rivera Law Project, the Legal Aid Society, many, many years ago, the Northwest Justice Project, and I've not done a legal case that I know of, but I've done some work with NCLR around policies for trans athletes to compete but not, like, a lawsuit.

Q. What is Sylvia Rivera?

A. Sylvia Rivera is a law project in New York that focuses on transgender people, especially those who are disenfranchised by race or poverty.

Q. What was your involvement with

Sylvia Rivera?

A. Again, a lot of the kind of curbsiding, hey, what do you think about this. There was one case, again, many years ago, where there was a prisoner in New York and they were going to force her to have her head shaved when she entered prison because they were putting her in a male prison. The Cruz V. Zucker case is the one that I'm not entirely sure who the counsel was for because it was somebody who had worked at SRLP and now works for the ACLU, and so I don't know if that was with them or not. I know the person, but not who they were working for.

Q. Wouldn't surprise you if Sylvia Rivera, that organization, was involved in the Cruz case?

A. No, it wouldn't surprise me.

Q. And then Legal Aid, what kind of work have you done with them?

A. I think they were involved in Cruz V. Zucker.

Q. Is that all?

A. I think so.

Q. The Northwest Justice Project, what

is that organization?

A. That's a law organization in Washington state that I worked with on two cases for transgender patients who were being denied payment for medically necessary care under the state Medicaid agency.

Q. Those were two Medicaid cases?

A. Yes. And I -- I don't know if it was considered testimony, but I phoned in and talked to an administrative law judge, so I think it was testimony, but it was -- it wasn't I went to a physical court.

Q. Any other work for the Northwest Justice Project?

A. Well, those were -- there were two cases, but that was it.

Q. Okay. And then NCLR, you said you did some work regarding policies for trans athletes. Could you tell me more about that?

A. I've gone with them to talk to -- for example, I went with them to talk to the California Boxing Board. I don't know if that's the exact name, but the -- the California state organization that regulates boxing on behalf of a trans person who wanted

to compete. I went with them to talk to a women's roller derby league once about changing their policy, and I also worked with them in providing some medical background and sort of technical assistance when they were working with the NCAA to draft their trans athlete policies, and that was, like, in 2011, I think. And I'm actually working with them now because those are going to be reviewed, but that's in process.

Q. Okay. Other than that one case you mentioned where you were representing or the expert witness for a physician defendant, have -- has all of your work as a medicolegal consultant or expert been on behalf of advocacy groups like Lambda Legal, Northwest Justice Project, ACLU, et cetera?

A. There -- I've worked with legal groups, and like I said, also NCLR on more of a -- not a lawsuit thing, but just technical assistance to help them and to help the NCAA write their policy. I should also add, I've actually worked with the Transgender Law Center too, though not in the past few years.

Q. Is that another group like Lambda

Legal?

A. It's a California-based organization that, many years ago, was more of a direct services organization, and now they don't do that as much, and so when they were doing direct services, I did more work with them on behalf of the individual clients, like not going to court, but talking to some third party that had a sex-segregated facility and saying, gee, this is why you should let trans women use the women's facilities and trans men use the men's facilities.

Q. What is a direct services organization? What do you mean by that?

A. Instead of -- like, the ACLU provides services to clients, but they're not providing more mundane services, so they worked with a lot of people just to get their driver's license changed in California. Even though it's a pretty easy process to do that, some people, because they lack experience or resources, find that difficult, so they would work with a lot more individual clients.

Q. Okay. You've mentioned a few cases where you served as an expert witness involving

challenges to laws or regulations by the government, right?

A. I'm not sure what you --

Q. Well, the driver's license case, that's a law or regulation prohibiting people in Alabama from having the sex identifier on their driver's license from changing unless they had a certain amount of surgery, right?

A. Correct.

Q. In this case, it's a challenge to a law or regulation involving when the sex identifier on a birth certificate be changed, right?

MS. INGELHART: Objection. Calls for a legal conclusion, but you can answer.

THE WITNESS: Yeah. My question was did you mean the Medicaid cases and the payor cases? 'Cause those are agencies, but they're not --

Q. It's a regulation promulgated by a governmental agency?

MS. INGELHART: Again, objection.

Q. If you don't know, you don't know.

A. I think a lot of those cases were -- like, the prison cases, they have

policies in the prison that say we don't do X.

Q. Right. And that's -- you know, the policy of the prison itself or maybe the Bureau of Prisons or whatever the equivalent is in whatever state you're testifying in, right?

A. Exactly.

Q. In any matter that you've been retained as an expert witness involving a challenge to a law, regulation or governmental policy, have you ever concluded that such law, regulation or policy was valid?

MS. INGELHART: Objection. Calls for a legal conclusion. You can answer.

THE WITNESS: I generally think about it as the particular medical needs of the plaintiffs in these cases, and so I'm not so much saying this isn't valid, I'm saying for these people, this is not appropriate. It's not what is the standard of medical treatment to transgender patients.

Q. So you -- you don't -- you haven't offered an opinion on the validity of any law, regulation or policy?

MS. INGELHART: Objection. You can answer.

THE WITNESS: I don't -- I don't really know if you would consider what I've said in those cases to be a challenge to it, but if, for example, there's a law that -- or there is a policy that says transgender people shouldn't, in any circumstances, get surgery, then, yeah, I think that's wrong because in many cases, transgender people do need surgery. As far as saying this should be changed, how it should be changed, my -- my point is usually whether or not something is medically appropriate. I'm not a lawyer, so...

Q. You're not looking at the constitutionality of something or whether the government has a right to do a thing, your testimony or opinion has always been regarding whether or not the outcome of the policy or law is medically appropriate for the plaintiff, right?

A. I think that's fair, yeah.

Q. And I don't want to try to confuse you. In the Alabama case, for example, there -- they don't allow transgendered individuals to change their driver's license unless they've had a certain amount of surgery,

you've already testified to that. Your opinion isn't that that law is somehow unconstitutional or illegal, it's that for those plaintiffs, it's medically appropriate for them to change their driver's license without that amount of surgery, right?

MS. INGELHART: Objection. Calls for a legal conclusion. You can answer.

THE WITNESS: I couldn't tell you if something's constitutional or not. I mean, I took civics in high school and a few classes in college and history, but that's not my area of expertise. But I can say that for individual patients or for the transgender community at large, something is inappropriate. For example, in the Alabama, there might be people who have medical contraindications to surgery, and saying you can't have this important element of social transition because it's too medically dangerous for you to get this other medically necessary treatment is just bonkers. It's -- it's not appropriate.

Q. Okay. And in this case, it's your opinion that it would be medically appropriate for the plaintiffs here to be able to change

the sex identifier on their birth certificate, right?

A. I think it's medically necessary for transgender patients to be allowed to change the gender marker and the name on all of their identity documents.

Q. Have you been asked by plaintiffs' counsel to provide a rebuttal to the opinion submitted by Dr. Van Meter and his expert report?

A. I think in my report, I actually commented on Dr. Van Meter's report.

Q. Yeah. So that's my question is have you been asked by plaintiffs' counsel to provide a rebuttal to the opinion provided by Dr. Van Meter and his expert report?

A. They gave me a copy of his report and they said if you think anything's important to comment on in your report, comment on it.

Q. And what you're just leafing through there, Defendants' Exhibit 19, those comments are included in that report, right?

A. Yes.

Q. In fact, Paragraph 2 of your report says: I have been asked by plaintiffs' counsel

to provide my expert opinion to respond to and rebut the opinions offered by Dr. Quinton L. Van Meter in his expert report in order to show how Ohio's policy refusing to provide accurate birth certificate gender markers for transgendered people born in Ohio harms transgender individuals.

You see that, right?

A. Yes.

Q. Is that the only opinion you were asked to render in this matter?

A. I was asked to talk about the -- the policy, the central element to, I think, what this litigation's about, like should transgender people be allowed to change their birth certificate.

Q. And you said "the policy." You're talking about the policy of defendants to not allow transgendered individuals to change their birth certificate on -- to change the birth certificate because of their gender identity, right?

A. Correct.

Q. Did you -- before rendering that opinion, did you review any materials?

A. I reviewed the -- I think it's called the complaint, like, the suit premises, I guess. I reviewed Dr. Van Meter's report. In the course of all of this, I reviewed Dr. Ettner's report, but I don't think that was before I wrote my report. I'm not entirely sure, but I don't think so. I think that's it. I mean, there's been a couple other things that they've sent me subsequently, but that was the crux of -- the complaint and Dr. Van Meter's report.

Q. What other things did they send to you?

A. Like I said, Dr. Ettner, I think Dr. Van Meter wrote a report about Dr. Ettner's report.

Q. So his rebuttal report?

A. I think that's what you call it, yes. I think that's it, but there might have been something small in addition, but those are the ones that I remember that stand out to me.

Q. Do you -- well, which opinions of Dr. Van Meter did you rebut in your -- or respond to in your report?

MS. INGELHART: Objection. Vague.

You can answer.

THE WITNESS: In regards to Dr. Van Meter's report, I think he came to conclusions that are very much in contradiction to what is accepted by the broader medical community as far as treating trans patients, and his views on that are pretty fringe. I think he also underestimated the number of people who have DSDs. He also seemed to say that there was no biologic basis for people being transgender, and I think the research literature doesn't support that. I think he also underestimated the incidence of transgender people in general. I think his assumption about the karyotypes of the plaintiffs and being sort of absolutely definitive about that was -- nothing was a scientifically accurate way to describe that because we know that transgender people, when compared to cisgender or non-transgender people actually have a higher rate of abnormal karyotypes. I may have said other things, but I think those are the high points.

Q. Did you provide an opinion regarding the harm caused by inaccurate birth

records to transgendered people?

A. Yes.

Q. Do you know whether Dr. Van Meter provided an opinion as to harm or potential harm caused by inaccurate birth records?

MS. INGELHART: Objection. Foundation, but you can answer.

THE WITNESS: I think he had the opinion that birth records should not be changed, and while I don't think he described the harms that would come from that, I think the harms that would come from that are pretty obvious to anybody who takes care of a lot of transgender people. I don't have his report in front of me, though, so I can't tell you for sure, but I don't recall him specifically saying, yes, we shouldn't allow people to change their identity documents and these are the bad things that will happen to them if we do or if we don't.

Q. This was a document which was previously marked as Defendants' Exhibit 19 -- or 18, sorry, which is the expert report of Dr. Van Meter. Where in this report does Dr. Van Meter conclude that birth records

should not be changed?

A. On Page 5 in his conclusions, he says that No. 29: Ohio birth certificates record an individual's sex.

Q. Do you disagree with that?

A. I disagree with Dr. Van Meter's definition of sex in subsequent paragraphs.

Q. Okay. So do you disagree with the statement that Ohio's birth certificates record an individual's sex?

A. Using my definition of "sex" and not Dr. Van Meter's, I think that's reasonable, but I also don't think it's always correctly recorded.

Q. How does your definition of "sex" differ from Dr. Van Meter's?

A. From his points in his conclusion, it seems that he says that chromosomes are the determinant of sex and always align with what he thinks sex is, and that that should be what is utilized for Ohio's birth certificate.

Q. And you disagree with that because?

A. I think it's very simplistic to think that sex is only what your external genitals look like or what your chromosomes are

or that what your external genitalia look like reflects what your chromosomes look like. I think sex is a much more complicated concept.

Q. If you turn to Paragraph 3 of Dr. Van Meter's report, there's a heading that says -- sorry, not Paragraph 3, Page 3, there's a heading that says: Biological sex is binary. Let me know when you're there.

A. I'm there.

Q. And if you look at Paragraph 14, it says: From the moment of conception, a fetus is determined to be either a male XY, female XX, or in rare cases to have a combination sex determining chromosomes.

Do you disagree with that statement?

A. I think that at conception, every fetus has sex chromosomes. Most of the time, those are either XY or XX. In rare cases, though not as rare as he suggests later in his report, those are either not XX or XY. They might be just one X, two Ys, or in some cases, the gene on the Y chromosome that sends you down the typically male developmental pathway is actually moved onto the Y chromosome.

Although while chromosome abnormalities are often not compatible with life, actually sex chromosome abnormalities are some of the ones that are the most compatible with life.

Q. So you disagree with Dr. Van Meter on the rate of such abnormalities, but just so everyone is on the same footing, I mean, are we talking about one percent of the time, half a percent of the time, three percent of the time?

A. I'd say half to a quarter of a percent of the time.

Q. Okay. So he may be, you know, a hundredth of a percent of the time or whatever, but you still acknowledge that it's exceedingly rare these type of chromosomal abnormalities, right?

MS. INGELHART: Objection. Mischaracterizes prior testimony, but you can answer.

THE WITNESS: One in 200 isn't exceedingly rare. That's more common than kids who have cystic fibrosis or kids who have sickle cell, so it's not exceedingly rare. It's uncommon, it's rare.

Q. Okay. So I guess without getting

into the definition of how he's using the word "rare," you would agree, then, that from the moment of conception, a fetus is determined to be either male, XY; female, XX; or in rare cases, to have a combination of sex determining chromosomes, many of which are not compatible with life, and some of which are the cause of identifiable clinical syndromes. You agree with that, right?

MS. INGELHART: Objection. Mischaracterizes prior testimony. You can answer.

THE WITNESS: I don't think that's exactly what I said. I think what I said was that at fertilization, most fetuses are XX or XY, and if you're XY, it sends you typically down the pathway for male reproduction, but that doesn't determine your sex. That's one aspect of biologic sex that should be taken into consideration, but is not the determining factor for sex.

Q. And when you say "most," you mean 99 out of a hundred or less?

A. Ninety-nine out of a hundred or less is --

Q. If you could go back to Page 5 of Dr. Van Meter's report.

A. I'm there.

Q. And you look at Paragraph 30, it says: Gender identity is not observable or detectable at the time of birth.

Do you see that?

A. Yes.

Q. Do you agree with that conclusion?

A. Not entirely.

Q. You believe that there are mechanisms by which you can detect gender identity at the time of birth?

MS. INGELHART: Objection. Misstates, mischaracterizes prior testimony. You can answer.

THE WITNESS: In the case of children with intersex conditions, that we have reasonable research that tells us as adults, this child is likely to identify as male or female, you can talk about that. So you can say in XY fetuses that are born with complete androgen insensitivity syndrome, virtually all of them identify as women in adulthood, whereas XY fetuses who have five alpha reductase

inhibitor deficiency, it's 60/40 as to whether or not they identify as male or female in adulthood. You can also say with most people who don't have an intersex condition, that if they're XY, they'll identify as male in adulthood and if they're XX, they'll identify as female, so you can make an educated guess, but that's going to be wrong sometimes.

Q. So if you turn to your report, Defendants' Exhibit 19 and you turn to Page 4, look at Paragraph 14, let me know when you're there.

A. I'm there.

Q. You define gender identity as the internal sense of one's self as, for example, being a male or female. Do you see that?

A. I do.

Q. What -- how can you determine someone's gender identity as a newborn if it is the internal sense of one's self?

A. As I said, you can make an educated guess based on information available to you at the time. So if you have an XY fetus that has complete androgen insensitivity syndrome, it's a pretty good guess that that child is going to

identify as female in adulthood. If you have an XY baby who -- that we can find has no detectable intersex condition, you can make an educated guess that as an adult, that child is going to identify as female. So you can't say with certainty, but you can say the odds that something is going to be the case.

Q. So isn't that what's already happening when a child is born in Ohio in and the medical provider looks at the external genitalia, they say that looks like male external genitalia. Pretty good guess that that's an XY chromosome child, right?

A. Exactly. It's a pretty good guess.

Q. And then it's a pretty good guess, based on your testimony, that their internal sense of one's self, their gender identity is also going to be male, right?

A. Again, that's a good guess.

Q. Okay. But you can't know for certain what the gender identity of a child is going to be based on their external genitalia, right?

A. Or karyotyping or anything.

Q. Or karyotype or if they're born

with intersex conditions, right?

A. Correct.

Q. Certainly can't ask them?

A. Not at that age, no.

Q. Getting back to Dr. Van Meter's report, and I just want to close sort of this line of questioning. Where in Dr. Van meter's report does he discuss potential for harm caused by the policy of defendants or the law related to when Ohio will change the sex identifier on a birth certificate?

A. Again, I don't see where he did talk about the harm that this experience by trans people who don't have accurate identity documents.

Q. So to the extent your report gives an opinion on the harm that's caused by the mismatched identity documents, that's not in response to Dr. Van Meter, right?

MS. INGELHART: Objection. Mischaracterizes testimony in the report, but you can answer.

THE WITNESS: Well, there's two answers to that question. The first is my opinion about that is based on my almost 15

years of experience treating a lot of transgender patients, many of whom weren't able to easily change their gender identity documents, and so seeing the harms that those people suffer. But I think, also, when I heed Dr. Van Meter's report, it seems to me that he thinks that it is appropriate to not change identity documents for transgender people. It may be the case that he just has not taken care of enough transgender people to realize what harms they suffer, and I always assume that people are trying to do the right thing, and so he doesn't talk about that, but I think that's an omission on his part and a lack of understanding on his part.

Q. So he doesn't talk about whether or not it's appropriate to change identity documents, right?

MS. INGELHART: Objection. Mischaracterizes, but you can answer.

THE WITNESS: No. I think he does talk about it.

Q. Where does he talk about the appropriateness of changing an identity document?

A. In his conclusions, he says: Ohio birth certificates record an individual's sex. That's Paragraph 29. And then he goes on to state that the plaintiffs' sex is -- essentially, their sex is assigned at birth. So taking those two points together, it seems he thinks that the sex you're assigned at birth should be the sex that determines your -- or the sex that is listed on your birth certificate.

Q. But he doesn't explicitly say that, right?

MS. INGELHART: Objection. You can answer.

THE WITNESS: I mean, it's kind of obvious. He says they record sex. I think the plaintiffs' sex are not what the vast majority of transgender health care providers would describe as their sex. And, you know, if he says it should record sex and this person's sex is male, he's essentially saying that person's sex should be recorded on their birth certificate as male.

Q. And then he doesn't go into whether or not that would harm them in any way, right?

A. Not that I recall, but I -- it took me a while to read his report, so rereading it again here would take some time too.

Q. Did you reduce all of your opinions in this matter into your written report?

A. There's a -- this is a very complicated subject, so I gave what I think is a summary of my opinions. But did I put every bit of knowledge that I have that informs that in there, no.

Q. Okay. Are you being compensated for rendering your opinion in this matter?

A. Typically, in cases where the plaintiffs' attorneys are representing the plaintiff pro bono, I waive compensation for hours, but I do expect my travel time compensated -- or not travel time, travel expenses compensated. So in this case, I waived, for the ACLU, my expert witness fee because they are representing these patients pro bono.

Q. But you expect to be compensated for your expenses, flight, hotel room, things like that, right?

A. Exactly.

Q. All right. Exhibit 19 also includes a copy of your CV and bibliography, Exhibits A and B, right?

A. Yes.

Q. All right. If you turn to Exhibit B, which is a copy of the bibliography, are these materials that you relied on to form your opinion in the report?

A. They're things that I cited in my report and there are a few things that, for example, the National Transgender Discrimination Survey, that has a lot more information than what I may have cited in my report. And so some of these things are citations and some of these things are, I think, important data points from the literature.

Q. Okay. So to the extent that items in your bibliography are cited in your report, you would have relied on them in forming the opinions in your report, right?

A. Those places where they were particularly cited.

Q. Okay. Are there any other materials in the bibliography that you relied

on in forming the opinions in your report?

A. For example, the standards of care, I mean, that's sort of how I practice.

Q. Are you talking about the WPATH standards of care?

A. Yes. Correct.

Q. Where are those located?

A. It's on the first page, halfway down, Coleman E., Bockting.

Q. Okay. Anything else?

A. The Toronto guidelines are a good example of trans health care or guidelines.

Q. Where is that one?

A. That's just above the other one, Bournes, A.

Q. Okay. Any other ones?

A. I'm honestly not sure which ones are cited ones or which ones aren't.

Q. Well, the ones that are cited are cited in there. Those ones are just easy to find, right? I mean, you've got TransLine, footnote one, retrieved from http project-health.org/TransLine. I don't know if that's in your bibliography, but that was something that was cited, right?

A. So let's just go down them. So the first one, the AAP, I think that was a citation. The second one, the APA Task Force, that may have been a citation, but it's also just kind of a good general document. Bauer, I cited. Bentz, I cited. Bournes, we talked about. Byne and Bradley, that might be a citation, but it's also just generally a good document. We talked about the standards of care. Collin, I cited. Coolidge, I cited. Diamond, I cited. Fraser, I'm not sure if I cited, but it's also just generally a good article. My own paper, I'm not actually sure if I cited it. I know that sounds dumb. The National Transgender Discrimination Survey, we talked about. Hare was a citation. Hembree is the Endocrine Society's guidelines, so I may have cited that, but that's also just a generally good document. Henningsson, I cited. Inoubli, I cited. James, et al., it's that same National Transgender Discrimination Survey. Lee, I cited both of them. Lehavot, I cited. Makadon is, again, just a good guide. I may have cited it, but I'm not sure. Seaborg is a citation that Dr. Van Meter used, so I

went -- in commenting that, I cited it. Southern Poverty Law Center, I cited when talking about the American College of Pediatrics. And Wieckx, I probably cited that, but it's also just a good general study that I may have included.

Q. All right. So, I mean, it sounds like you relied on pretty much everything in your bibliography, then, right?

A. Some things are specific citations and some things are just generally good transgender medicine.

Q. All of which you relied on in forming the opinions in your report, right?

A. In some way or other, yes.

MS. INGELHART: Excuse me. Could we take another break? You're close? I can wait.

MR. BLAKE: Let's finish up bibliography stuff and then we'll break for lunch.

MS. INGELHART: Sure.

Q. Other than the materials we discussed, you know, the complaint, the report of Dr. Van Meter, Dr. Ettner's report,

materials in your bibliography, did you review or rely on anything else in preparing your expert opinion?

A. In preparing my report?

Q. Uh-huh.

A. Not that I can think of, but there's a lot of literature that I have in the brain, so...

Q. I get it, that some knowledge is just general knowledge, right? I mean, in some way, shape or form, you're relying on stuff you learned in medical school?

A. Exactly.

Q. But talking specific to this report?

A. Correct.

Q. And did you review, at any time, whether in preparation for the report or subsequent to your report, did you review the motion to dismiss or any of the related pleadings?

A. I reviewed the motion to dismiss, which they sent me last week, maybe.

Q. Okay. So that was in preparation for today?

A. I think that was -- I don't know if it was in preparation, but this is part of the case, so...

Q. Okay. Did you review the order related to the motion to dismiss?

A. What the judge said?

Q. Yes.

A. I actually think -- I'm not sure -- I read the judge's response to that.

Q. Okay. Not the pleadings underlying the order?

A. I don't think so.

Q. Okay. Did you review any of plaintiffs' discovery responses?

A. I don't know what that is.

Q. Okay. Then I'll take that as "no" for now, and if we look at them later and you say "I did see this," I won't crucify you for it.

A. Sure.

Q. Did you interview any of the plaintiffs at any time?

A. No.

Q. And I assume you haven't conducted any medical or psychological examinations of

the plaintiffs?

A. No.

Q. Have you ever met any of the plaintiffs in this matter?

A. Not that I know of.

Q. Have you spoken to anyone else aside from your counsel, but have you spoken to anyone else in connection with this matter since rendering your opinion?

A. No.

MS. INGELHART: Objection. Vague. I'm sorry. You can answer.

THE WITNESS: No. Just the attorneys.

MR. BLAKE: All right. Yeah, we can take a break.

MS. INGELHART: Cool.

(Luncheon recess taken.)

AFTERNOON SESSION

CONTINUED EXAMINATION OF RYAN GORTON, M.D.

BY MR. BLAKE:

Q. We're going to turn to Exhibit A of your expert report, Defendants' Exhibit 19. Go ahead and turn to Exhibit A.

A. Okay.

Q. And this is a copy of your CV, correct?

A. Correct.

Q. You noted there was an update regarding the GEI certification, right?

A. Yes, and one additional talk.

Q. Okay. So would that GEI certification, would that be listed now under your licensure and certification?

A. Yes.

Q. And fair to say September 2019 through present?

A. I think they --

Q. October?

A. It might have been the first of October they sent me the result.

Q. Okay. So October 2019 through present, that's the GEI?

A. Correct.
Q. And you said there was one additional talk?
A. Yes. I gave a plenary at the Gay and Lesbian Medical Association in September.
Q. Okay. So September plenary at -- I'm sorry, the what again?
A. GLMA, the Gay and Lesbian Medical Association, GLMA.
Q. Okay. Any other updates?
A. No.
Q. Okay. So your professional practice, you've listed the things we talked about earlier, your work at Sutter Davis, the work at Saint Tammany, and you have, underneath volunteer activities, this Lyon-Martin work; is that accurate?
A. Yes.
Q. So are you paid for the primary services you provide at Lyon-Martin?
A. No. I work pro bono there.
Q. But you're paid for your work at Sutter Davis, right?
A. Yes.
Q. You've never worked as a

psychologist, right?

A. No.

Q. And your medical training is not in the field of molecular geneticist, right?

A. Genetics is a part of medical school, but I don't have a degree in that.

Q. Okay. You're not an expert in genetics?

A. I have as much expertise in genetics as most physicians would have.

Q. But not as much as a geneticist?

A. Correct.

Q. And you don't have any expertise in endocrinology either, right?

A. Again, that's a part of general medical practice, and so I treat patients with endocrine disorders, but I do it as a primary care provider.

Q. And I have any -- well, do you refer your patients to endocrinologists as part of your practice?

A. Rarely, but sometimes.

Q. When there's, like, some sort of special need to do so?

A. Often, it's diabetes management.

Q. Okay.
A. That is more than typical diabetes management of primary care.
Q. So like your familiarity with genetics, would you say that your knowledge of endocrinology is as much as any other physician?
A. I would say probably a little more than average in that I treat a lot of transgender patients and their endocrinology issues with those, so as part of my practice, I do more of that.
Q. But your expertise would be certainly less than someone who's a trained endocrinologist, right?
A. Yes. Absolutely.
Q. Your professional affiliations, are those also current on Page 2?
A. The two in the middle are prior ones that I gave years for. I'm still a WPATH member and I'm still -- I'm the GLMA medical expert's panel, which is basically just a running list of people that can refer to.
Q. For the World Professional Association for Transgendered Health

Membership, what are the qualifications to be a member of that organization?

A. To be a member, I don't know if there's a specific restriction. I mean, there are students who are members, there are medical professionals, mental health professionals, some lawyers who are members, so I don't think there's a cutoff for it. Obviously, for GEI certifications, there is, and if you participate in committees, it's usually because you have some expertise in that area.

Q. Usually, but not always?

A. I'm not on all the committees, so I don't know who's on all the committees, so I couldn't tell you, but...

Q. The Transgender Medicine Research Committee and the Institutionalized Persons Committee, do those require any special degree or certification to be a member of the committee?

A. Medicine Research Committee, I think it's more of your interest in it. Medical students can be members. The Institutionalized Persons Committee, I don't know if there's requirements, but most of the

people there have experience in that area. In fact, everybody that I know who's on it has experience in that area and you're asked to participate if you're knowledgeable.

Q. Okay. But you're not aware of any specific criteria or certification which you need in order to join either of those committees?

A. That I know of, no.

Q. Are you an officer at WPATH?

A. No.

Q. Would you agree that WPATH's -- one of WPATH's primary missions is advocacy on behalf of transgendered folks?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: In the sense that health care providers, in treating many different conditions, have to be advocates for their patients, yes.

Q. You've listed about two pages worth of publications and papers on Pages 2, 3 and 4 of your CV. Do you see that?

A. I do.

Q. Did you rely on any of these

publications or papers to form the opinions expressed in your expert report?

A. A lot of the knowledge that informed my expert report was the same knowledge that informed writing those papers or co-writing those papers, and so the knowledge base is the same, but it's not like I went back to one of these and read it before I created my report.

Q. Did you go back and look at any of them in creating your report?

A. If I used the first one, Gorton and Berdahl, as a citation, I think I may have gone back to look at that to get the correct point.

Q. Okay. Any others?

A. That I remember, no.

Q. Same question for your presentations, did you go back and look at or rely on any of the materials that are -- that were part of these presentations or talks?

A. That I can think of directly, no.

Q. All right. Go to Paragraph 14 of your opinion. It's on Page 4 of Defendants' Exhibit 19. Are you there?

A. I'm there.

Q. All right. This is the definition of gender identity that we read and discussed earlier. Do you recall that?

A. I do.

Q. Are there any other definitions of gender identity that you're familiar with?

A. There are a lot of different ways of stating this, but I think the general idea that gender identity is the internal sense of one's self as a man or a woman or somewhere on the spectrum between those is reasonably accepted.

Q. You didn't use "spectrum" here to describe gender identity, did you?

A. No. I just used, for example, being male or female because that's the most common identities.

Q. But you would also include the concept of a spectrum as also defining gender identity?

A. There are transgender patients that I've treated who don't feel like they belong in either the male or female category and that they're somewhere along that spectrum, and so, yeah, people do define that way.

Q. Okay. Let's look back at Defendants' 20, which is the declaration you gave in the Whitaker case. And if you turn to Page 4 of that document and look at Paragraph 11, let me know when you're there. Are you there?

A. Yes.

Q. Gender identity is each individual's internal sense of themselves as belonging to a particular gender such as male or female. So similar to what you described in your expert report in this case in Paragraph 14, but not identical, right?

A. No, because I might write the same thing slightly different.

Q. But in your mind, those two are pretty close?

A. Yes.

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(Thereupon, Deposition Exhibit 21, Declaration, was marked for purposes of identification.)

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Q. You've just been handed what has been marked as Defendants' Exhibit 21, and if

you flip through it, you'll see that this is a declaration that you provided in the case of Edmo versus Idaho Department of Correction. Do you see that?

A. Yes.

Q. Does this appear to be a true and accurate copy of that declaration?

A. I haven't read the whole thing, but I'm assuming it's correct.

Q. Okay. If you go to Paragraph 18, which is on page -- well, 35 of 100 of the document, but Page 6 of the declaration, you define gender identity as the hardwired internal sense of one's gender. Do you see that?

A. Yes.

Q. That's a very different definition than you used in the other two declarations, correct?

MS. INGELHART: Objection. Misstates and mischaracterizes prior testimony.

THE WITNESS: I don't see that.

Q. Well, what did you mean by "hardwired"?

A. That in adults, this isn't

something that really changes.

Q. Okay. So how is that similar to what you've defined as the internal sense of one's self as, for example, being a male or female?

A. So in adults, people have a gender identity. Everyone has one. Transgender people, non-transgender people, and it doesn't really change in adulthood to an appreciable amount.

Q. So what does gender identity have to do with being an adult?

A. Gender identity in preadolescent children can sometimes be fluid and change. Typically, once early adolescence has commenced, it's fairly fixed, and by adulthood, completion of puberty, it's not really something that can be changed.

Q. So I don't see that in your definition -- any of these definitions, gender identity, this concept of fluidity as a child or being fixed as an adult. Is that somehow implicit in some of the words that you've chosen to use here?

A. In each of these documents, I'm

trying to explain a very nuanced concept, and so to not make every declaration the size of a book, I try to provide a working definition, which I think there's a lot of aspects on gender identity that we could talk about that they're not needed to talk about the definition in the sense that I'm using it in the document. In this document, it's about an adult trans person, so I don't really feel the need to say, well, gee, when she was seven, her gender identity might have been different because that's not at issue here.

Q. Would you agree that based on the fluidness of a child's gender identity, it would be impossible for the State of Ohio or anyone to identify the gender identity of a newborn?

MS. INGELHART: Objection.

THE WITNESS: Again, as I said before, you can make an educated guess, and that educated guess might be 99 percent likely to be correct.

Q. But it would just be a guess?

A. An educated guess. A guess is flipping a coin, so you can say based on the

information I have about this child in front of me, 99 percent chance this child is going to identify as male or female as an adult.

Q. Is gender identity hardwired when someone is a child?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: Kids can be very fluid about a number of different aspects of their identity. This is one of them. In some children, even preadolescence, it's really obvious this kid's gender identity is male or female. In some kids, they may identify as both or different at different times. So in the majority of children, you could say, yes, this kid identifies as male now, 99 percent chance, ten years from now when they're 18, they identify as male, but there are some kids, and they're a minority, that their gender identity, again, is fluid in preadolescence.

Q. So in those cases, gender identity is not hardwired?

A. No, it's hardwired, it's just developing.

Q. So it's hardwired, but changing?

A. So, for example, a child who is transgender with or without an intersex condition, they're -- with or without a detectable intersex condition, their gender identity is influenced by their genetics, their prenatal environment, and those are things that we know affect that. And so the things that push people towards one identity or another is relatively fixed because if a kid has an intersex condition, like, for example, five alpha reductase inhibitor deficiency, it's about 60/40 do they identify as male or female in adulthood. And so you can say this kid has five alpha reductase inhibitor deficiency and they may identify as male or female in adulthood, and right now, the child might not have figured that out, might not have gone through the developmental stages necessary for that to be a certain thing. So the -- the things that affect gender identity are fixed, some of them are. The things that -- or -- but the child's ultimate gender identity may not be fixed.

Q. The internal sense of their gender is hardwired?

MS. INGELHART: Objection. Misstates and mischaracterizes. You can answer.

THE WITNESS: Let me give you another example. So there are genes that determine height, and so -- and there's some of these that we know. And so you can say this child is born with genes that will very likely make them quite tall, but if that kid, during childhood and adolescence, has nutritional problems, they may not become tall, they may be quite short as an adult, right, but it doesn't mean you can't say there are things that are hardwired that are going to affect this child's height in adulthood. It's just you can't predict that on a two year old 'cause you can't say, gee, this two year old is going to develop short gut syndrome and be chronically malnourished so they're going to be short anyway. Even though they have the predisposition to be tall, they're going to end up short.

Q. Which genes indicate a person's gender identity?

A. There's a lot of different genetic

aberrations that can affect that. For example, five alpha reductase deficiency. There's a number of genes that form the group of diagnoses of congenital renal hyperplasia, complete androgen sensitivity syndrome, that's the androgen receptor. There are a lot of different things that can influence this from a genetic perspective. I think I also cited a few papers that talked about this gene is more common in trans patients, though we don't know everything.

Q. Those are all DSDs that you just talked about, the five alpha, the androgen insensitivities, right? You would all qualify those as DSDs, correct?

A. Those patients can have DSDs and be transgender, and I have had transgender patients with those diagnoses. They're not mutually exclusive.

Q. I understand that. But I asked you whether or not there were genes that determined someone's gender identity, and I think you just gave me a list of several DSDs, right?

A. Genes that can affect people's gender identity.

Q. Okay. But those were all DSDs, correct?

A. The ones that I gave you examples of, yes.

Q. So there are transgender people that have DSDs, right?

A. And more commonly than people without DSDs who are trans, yes.

Q. And there are folks that have DSDs that aren't transgender, right?

A. Correct.

Q. And then there are transgendered folks that do not have DSDs, right?

A. Yes, but it's probably the case that there's a certain percentage that have DSDs we're just not aware of.

Q. Okay. But you would agree that there are people without DSDs that are transgendered?

A. Correct.

Q. So those DSDs, while they may, at least in your opinion, influence someone's likelihood or not to be transgendered, they aren't determinative of their status of a transgendered person, correct?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: The thing that determines whether or not somebody's transgender is their gender identity, which you can't figure that out with a blood test.

Q. There's no genetic test that would say, aha, that person is going to be transgendered?

A. There are genetic tests that can tell you about somebody's gender identity as an adult -- or tell you the likelihood of certain gender identity as an adult, but whether that person identifies as transgender is not something you could tell from a genetic test.

Q. Would you agree that an individual's internal sense of their gender is not hardwired when they are seven, six, five, a young child?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: I don't think that's -- again, it's what we talked about. Those things that influence your gender identity, known and unknown that medicine

understands and that medicine doesn't understand, are present and the die is cast in seven year olds.

Q. I'm talking about the internal sense, though, just that one specific internal sense of your gender, is that hardwired as a preadolescent, prepubescent young child?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: All of the things that we're talking about, gender identity, internal sense of one's self, they're biologically based in the same way that depression or anxiety is biologically based. It may be a mental health symptom, but it's because of the squishy organ between your ears that you experience that. Medicine's understanding of that is not always complete, but what we do understand is that there are things that will tend to make somebody transgender. We may not be able to identify the exact gene, but, for example, in twin studies, we know that identical twins who share the same prenatal environment and postnatal environment are more likely to be concordant

about whether or not they're trans than fraternal twins who share the same prenatal environment, postnatal environment, but they're no more genetically similar that siblings. So you can say yeah, there's something there and it's something in the genes because that's the only real difference between identical and fraternal twins, but I can't point to a specific gene on a specific chromosome that does that.

Q. So your statement that young children are hardwired and that gender identity is biologically based, is that solely based on the twins study?

MS. INGELHART: Objection. Compound and vague. You can answer.

THE WITNESS: There are a number of studies that I cited, the between study being one of them, Dr. Diamond's twin study, that indicate a genetic component to predisposition to being transgender, but it's not a definite, 100 percent thing, and that's the case with a lot of genes. I was talking about height. You can have all the genes predisposing you to be tall, but if you don't get enough nutrition in

early childhood, you're not going to be tall. So there are things that influence gender identity in adulthood that are present and fixed in preadolescence, but the manifestation of that, we're not certain of that. Just like the kids who has the genes to be tall, we're not certain they're going to be tall until they get to a certain height. We're not certain this kid identifies as a transgender person in adulthood until they get to a certain point in adolescence. But that doesn't change the fact that you know that there are things that predispose to that, to being tall, to being transgender, that are present from fertilization.

Q. So is it fair to say that, in your opinion, gender identity -- sorry, the predisposition towards a gender identity is biologically based, but not necessarily determinative of someone's gender identity?

MS. INGELHART: Objection. Compound. Vague. You can answer.

THE WITNESS: It's even more complicated than that. There are some things that are -- that have a great deal of influence

and some things that have a lesser influence, and so how much or how likely someone is to be of a male gender identity or a female gender identity in adulthood, you can tell with varying degrees of certainty, but nothing is absolute.

Q. Nothing with regards to gender identity is absolute?

A. As far as the development of gender identity throughout childhood and adolescence.

Q. What are some of the things that have a great deal of influence on a person's gender identity?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: Some of the things I already mentioned, certain DSDs like complete androgen insensitivity syndrome. They almost universally identify as women as adults.

Q. Anything else?

A. The more severe forms of adrenal -- congenital adrenal hyperplasia have a much greater likelihood of identifying male as adults.

Q. That's another type of DSD?

A. Yes. If you show me a child that is seven that has had a fixed, unwavering gender identity since they were two, I could say with pretty good certainty it's not going to change much. The children without that just absolute I'm a boy, I'm a girl in every aspect of their life, they've never come away from that, the ones who aren't quite that adamant about it, that's more iffy.

Q. Does your karyotype have a great deal of influence on your gender identity?

A. Having a Y chromosome that is not -- or sorry. Having an XY chromosome without the present of DSDs is pretty predictive of a male gender identity in adulthood, like 99 percent. Having two X chromosomes without a known DSD is pretty predictive about 99 percent or more of being -- having female gender identity in adulthood.

Q. External genitalia, does that have a great deal of influence on gender identity?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: We actually know from studies where they've had XY children who were

born without an apparent DSD who had either a circumcision mishap or another disorder that caused their penis not to develop, previously, for many years, they would say, well, let's raise this child as a girl and create -- do a vaginal plasty, create a vagina for her, and a lot of those kids didn't identify as female in adulthood. So if it's the case that you have a baby that has typical male genitalia without the presence of a known DSD, most likely, that's a person who's going to identify as male in adulthood. But if you take that kid's genitalia and, for some reason, change it, that's not going to make them change their gender identity. So the presence of genitals can be a clue, but it's not like that changes your gender identity one way or the other.

Q. The same would be for a child with intersex conditions, does that have a great deal of influence on their gender identity?

MS. INGELHART: Objection. Vague.

THE WITNESS: Depends on the intersex condition.

Q. Okay. So which intersex conditions have a great deal of influence on gender

identity?

MS. INGELHART: Objection. Vague.

THE WITNESS: An example I've already given was complete androgen insensitivity syndrome. That's basically the androgen receptor doesn't work. So you can have all the testosterone in the world, and that doesn't set off the changes in the cell that testosterone usually does, and those children almost universally identify as women in adulthood.

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(Thereupon, Deposition Exhibit 22, Declaration, was marked for purposes of identification.)

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Q. Just handed you what's been marked as Defendants' 22, which is a copy of a declaration you gave in the case Corbitt V. Taylor. Do you see that?

A. I do.

Q. And does this appear to be a true and accurate copy?

A. Same thing. I haven't read it, but I'm assuming you gave me the correct thing.

Q. Turn to Paragraph 11, which is on Page 4 of the document. It says: Gender identity is the internal sense of one's self as male, female or somewhere along the spectrum between the two, or as in the case of agender individuals, external to this spectrum. It should be noted that gender identity being a product of the central nervous system should be considered one of the characteristics when describing the sex of an individual.

Do you see that?

A. I do.

Q. Somewhat more of an expounded upon definition of gender identity than the other definitions we looked at?

MS. INGELHART: Objection. Misstates and mischaracterizes prior testimony. Vague. You can answer.

THE WITNESS: Again, like I said, it's a complex idea, and so depending on how I use it in a particular report, I may go into more detail or not, though they're all -- all of the ones we've talked about are true and I agree with them.

Q. This one, the one we just looked at

in the Corbitt declaration in Paragraph 11, Defendants' Exhibit 22 specifically calls out that spectrum concept that we talked about earlier, right?

A. Yes.

Q. Is it your understanding that Dr. Meter's opinions focuses on the distinction between sex and gender?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: I think he has an understanding of sex and gender that is far from mainstream.

Q. So you don't know if he distinguishes between sex and gender in his expert report?

A. I can't remember precisely. If you want me to take time to read through it, I can.

Q. So if you turn to Van Meter's report, which is Defendants' Exhibit 18, and if you turn to Page 4 of the report, look at Paragraph 21. Just above that paragraph, there's a heading which says: Gender identity is distinct from biological sex.

Do you see that?

A. I do.

Q. And then it goes on in Paragraph 21 to define gender, and he says: It is a term that refers to the psychological and cultural characteristics that have been traditionally associated with biological sex. It is a psychological concept and sociological term, not biological like sex.

Do you see that?

A. I do.

Q. So after reading that caption and that sentence from that paragraph, do you now understand that Dr. Van Meter reaches a conclusion about the distinction between sex and gender?

MS. INGELHART: Objection. You can answer. Calls for possibly expert testimony, speaking to another expert's opinion. You can answer, if you can.

THE WITNESS: I'm not -- are you talking about gender or gender identity?

Q. I'm talking about gender.

A. So I think he uses "gender" in a way that makes it clear that he thinks it has nothing to do with sex, and I think that's not

right.

Q. Yeah. I -- I'm not asking what your opinion is on that, I'm merely asking you whether you recognize that Dr. Van Meter reached a -- an opinion or opined on the difference or distinction between gender and sex. I'm not asking you whether you agree with that, I'm simply asking whether or not you recognize there is such a distinction?

A. Between gender and sex, yeah.

Q. Okay. You don't explicitly define "sex" in your expert report, correct?

MS. INGELHART: Objection.

THE WITNESS: Do you mean give a definition of it?

Q. That's right.

A. I think my expert report makes it clear what I think sex is.

Q. All right.

A. But I'm not sure I put a definition at the beginning. I could be wrong.

Q. You've got a terminology section, right, if you look back at your report, Defendants' Exhibit 19?

A. Okay.

Q. All right. And you define gender dysphoria in Paragraph 12, right?
A. Correct.
Q. Gender identity disorder in Paragraph 13?
A. Correct.
Q. And you say that's now referred to as gender dysphoria, right?
A. Yes.
Q. And gender identity in 14, right?
A. Yes.
Q. No other terms which you've explicitly defined; is that accurate?
MS. INGELHART: Objection. Misstates and mischaracterizes testimony. Answer.
THE WITNESS: I explained later on what I think sex is.
Q. Okay.
A. So I think I kind of did give you my definition in the body of the work.
Q. Why didn't you explicitly define "sex" in your expert report and terminology section?
MS. INGELHART: Objection.

Misstates and mischaracterizes testimony in the report. You can answer.

MR. BLAKE: I'll withdraw the question.

Q. Did you explicitly define "sex" in the terminology section of your report?

A. In the terminology section?

Q. Correct.

A. No.

Q. Okay. So why did you not explicitly define "sex" in the terminology section of your report?

A. Because when I was using "sex" in my report, I was talking about a very complex idea, and I felt it would be more appropriate to just spend time in the report explaining what that was rather than trying to give a short definition, as we discussed before. My definitions are sometimes very short, sometimes more detailed, but in this case, "sex" is such an important thing, I wrote more about it in my actual report.

Q. Would it have been possible to give a short definition of the term "sex" in your terminology section?

A. Sure.
Q. Why -- and you didn't, though, because you thought it was just too complicated for this subject matter or --
A. Honestly, I wrote the report and then I read through it and I said what should I give some quickie definitions for, and that's how I picked the ones that were in there.
Q. What is your definition of sex?
A. Sex is the combination of multiple biologic characteristics of -- since we're talking about people, of humans that usually places people into one of male or female groups, but there are some people, for example, transgender people and people with DSDs who don't fall exactly into those two boxes at the end based on the fact that one aspect is not congruent with the other aspects.
Q. Is sex binary or a spectrum?
A. I don't think it's binary. Spectrum's one way to describe it.
Q. You have described it that way, right?
A. It's a spectrum, but not a bell curve.

Q. Okay. I mean, in Paragraph 20 of your report, you say: Sex is the biological characteristics of an individual or organism that place it along a spectrum or in discrete categories, including male or female. Right?

A. Right.

Q. So it's a spectrum on the one hand or it's in a discrete category, including male or female, right?

MS. INGELHART: Objection. Asked and answered.

THE WITNESS: There are two discrete categories in humans, male or female, into which 99 percent of people fit, and then there's a spectrum between those two in which a much smaller number of people exist.

Q. So for the overwhelming majority of people, it is binary, male or female?

A. For the majority. I wouldn't say overwhelming.

Q. Ninety-nine percent isn't overwhelming to you?

MS. INGELHART: Objection.

THE WITNESS: No.

Q. Would you say gender is more or

less binary than sex?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: It's kind of apples and oranges, but I would say they're about the same.

Q. Okay.

MS. INGELHART: Can we take a short break?

MR. BLAKE: We haven't been going an hour, but we can take a very short break. We've only been going about 45 minutes, but yes, we can take a very short break.

(Recess taken.)

Q. So just to recap, we were talking about sex, male or female, for the majority of people being a binary classification, right?

A. The majority of people fit into the male or female bucket.

Q. One or the other, right?

A. Right. But true binary would imply that there's not people in the middle, but most people fit on one of those two.

Q. And that -- and you view gender as neither more nor less binary than sex; is that

accurate?

A. I think it is still the case that with gender, the same majority of people who fit into the two categories of male or female as far as sex also fit into the two categories, male or female, as far as gender. I think -- so the number of people who fit on those two ends is not significantly different. I think there's a little more -- there's a little more expression of gender with regards to being in the middle.

Q. Variation?

MS. INGELHART: Objection. Vague.

THE WITNESS: There's the same amount of variation, but people sometimes may express it more.

Q. Go ahead. I've passed you a document which was previously marked as Defendants' 12. And these are the standards of care, the most recent edition of the standard of care published by the WPATH. I'm sure you're familiar with this document, right?

A. Yes.

Q. If you turn to Page 16, there's a numbered list that starts on Page 15 and

carries onto Page 16. And No. 4, the first sentence says: Mental health professionals should not impose a binary gender.

Do you agree with that?

A. When you're working with transgender clients, yes.

Q. Okay. So despite the WPATH's standard of care which warns against imposing a binary view of gender on transgendered individuals, is it your expert opinion that the State of Ohio should nevertheless impose a binary expression of plaintiffs' gender identity on their birth certificates?

MS. INGELHART: Objection. Calls for a legal conclusion. Vague. Misstates and mischaracterizes prior testimony.

THE WITNESS: And I'm not sure what you're asking.

Q. We both agree that the WPATH says that mental health providers shouldn't impose a binary view on gender, right?

A. Correct.

Q. You testified -- or you, in your expert report, at great length, talked about the harm that occurs to people when they do not

have identity documents which match their gender, right?

A. Correct.

Q. Okay. So the identity document at issue here is a birth certificate, right?

A. Correct.

Q. The birth certificate can say male or female, right?

MS. INGELHART: Objection. Calls for a legal conclusion.

THE WITNESS: I think sometimes.

MS. INGELHART: Vague. You can answer.

THE WITNESS: They don't write a gender at birth if you're not sure if the child has a DSD.

Q. Does that apply to any of the plaintiffs here?

A. I don't think so, no.

Q. So for all intents and purposes of this litigation, plaintiffs are speaking either a male or female designation on their birth certificate, right?

A. That's my understanding.

Q. Okay. So that's a one or the other

designation, a binary designation, right?

A. What the plaintiffs are seeking, yes.

Q. Okay. And so despite what the WPATH says about -- about not imposing a binary view of a person's gender, you, nonetheless, think that in this case, the State of Ohio should impose that binary view on their birth certificate --

MS. INGELHART: Objection.

Q. -- related to someone's gender identity?

MS. INGELHART: Objection. Calls for a legal conclusion. Misstates prior testimony. Mischaracterizes prior testimony.

THE WITNESS: I think the WPATH standards of care here are trying to talk to mental health providers about how to do therapy with clients. That's a lot different than an agency that is giving identity documents to people, right. There are a lot of trans people who may identify as somewhere along that spectrum, but maybe closer to male, so it would be good for them to have "M" on their ID.

Q. So at least that part of the

standard of care you don't think necessarily applies to the birth certificates at issue here?

MS. INGELHART: Objection. Misstates prior testimony. Mischaracterizes prior testimony. Calls for a legal conclusion. Asked and answered.

THE WITNESS: I think the WPATH standards of care here are talking about how you treat people in therapy, and so that's different from how people are treated in society and how they get identity documents issued to them. I think the WPATH here is not speaking to agencies who provide identity documents, they're talking to therapists.

Q. So that's a "yes"?

MS. INGELHART: Objection. Asked and answered. Misstates prior testimony. Mischaracterizes prior testimony. Calls for a legal conclusion. You can answer.

THE WITNESS: I don't think they're the same thing. So saying to a therapist that if your client identifies somewhere on the spectrum between male or female, don't try to say to them you have to pick man or woman is

very different from saying to the patient, gee, you have a more masculine gender identity and expression. What would be the safest and best thing for you to have on your identity documents? So I think it is possible for a health care provider to both support a patient transitioning a binary option on an identity document while also understanding that that patient's gender identity may not fit exactly in those -- those boxes.

Q. Have you ever looked at an Ohio birth certificate before?

A. Not that I know of.

Q. This was previously marked as Defendants' Exhibit 1. It is the birth certificate for one of the plaintiffs in this matter. The word "gender" doesn't appear on the birth certificate, right?

A. Not that I can see, no.

Q. It states "sex," right?

A. Correct.

Q. This particular one states male, right?

A. Correct.

Q. As a medical provider, do you

understand the value of recording an individual's sex at the time of their birth?

MS. INGELHART: Objection. Vague. Calls for a legal conclusion. You can answer.

THE WITNESS: I understand that the state may want statistics about that, but I don't see the value beyond statistical analysis and providing -- otherwise, the whole birth certificate providing evidence that this person was born and they're a citizen.

Q. Well, like, for example, the statistical information regarding growth charts for infants is one way in which knowing a child's sex is relevant, right?

A. Yeah, but...

MS. INGELHART: Objection. Calls for a legal conclusion and vague. You can -- or not legal conclusion. Objection. Vague. You can answer.

THE WITNESS: Yeah, but pediatricians don't have a child walk into their office and say can you show me little Billy's birth certificate so I can make sure I'm using the right growth chart? They look at the kid and they talk to the parents and they

get a history, and that's what informs it.

Q. How is the information communicated to the organizations that create the growth charts, do you know?

A. I'm not sure what you're asking.

Q. How are the growth charts formed, do you know?

A. They've done studies on a bunch of kids and they follow them throughout childhood and say 95 percent of kids fall within this length and weight, and they're from research studies.

Q. And who compiles that, do you know?

A. They're kind of sort of -- it's old data. I mean, they haven't changed that much. The one thing that does happen is there are growth charts specific to certain kids, so you could get growth charts specific to kids with certain illnesses. But, I mean, it's been the same for a long time and it's just you studied kids and saw they grew this much by this age and you average it together. It's not something that changes often. And I don't think there's an agency that comes up with those, I think they're published in journals.

Q. To your knowledge?
A. Yes, to my knowledge.
Q. You're not a pediatrician, right?
A. No.
Q. When a person is born, do you have a general understanding of how the sex of that individual is determined?
A. Generally, yeah.
Q. And what is that?
A. The pediatrician or family practice doctor caring for the infant or sometimes the obstetrician or midwife attending the delivery does a relatively cursory examination of the child's genitals and says it's a boy or it's a girl or these genitals are atypical. We need more information.
Q. Should -- in your opinion, should the medical provider perform the more detailed examination of the genitals at the time of birth?
A. It's warranted if there are clues that this might not be normal.
Q. And do you have any understanding of whether or not a more detailed examination is conducted if there are circumstances which

warrant such an examination?
A. Yeah. Generally, kids who have a typical genitals undergo a -- an evaluation.
Q. A more thorough evaluation?
A. A more thorough evaluation.
Q. If a medical provider is providing the right level of care, right?
A. Medical or nursing provider.
Q. And you use the word "cursory" like it's somehow insufficient to determine the sex of a child, but, I mean, you don't think that the check or examination of a child at the time of birth is in any way insufficient, do you?
MS. INGELHART: Objection. Misstates prior testimony. Mischaracterizes and is also compound.
THE WITNESS: I think people look at a child's genitals and say male, female or I don't know, and that's something that happens really quick. You look at it. If it looks like a penis and a scrotum with two descended testicles, okay. That's it. That takes a second or two.
Q. Is that insufficient?
MS. INGELHART: Objection. You can

answer.

THE WITNESS: It is sometimes incorrect.

Q. How often is it incorrect, do you know?

A. So in the case of transgender people, I think that incidents is probably somewhere in the one in 200 to one in 500 range.

Q. So what do you mean in the case of a transgendered person? What do you mean by that?

A. So most transgender people have a gender identity that is different from their sex assigned at birth, and so in most cases, for transgender people, that assignment at birth is incorrect.

Q. But it's not your testimony that the doctor misidentified the genitalia at birth for transgendered people, correct?

MS. INGELHART: Objection. Misstates --

MR. BLAKE: That's why I'm asking for the clarification.

Q. That's not you're testimony, is it?

A. It is that the doctor does not have enough information at birth to 100 percent or to make that determination with a hundred percent accuracy.

Q. What is that determination?

A. The sex of the individual, of the child.

Q. So they've -- you don't -- so I guess I want to -- I want to back up.

How often does a medical provider misidentify the external genitalia at the time of birth?

A. If you add up all of the intersex conditions, the children with DSDs that may not be identified at birth, which is a lot of them, and those people who are transgender, half a percent.

Q. Transgendered people don't have misidentified genitalia --

MS. INGELHART: Objection. Vague.

Q. -- right?

A. No. They have an incorrectly listed sex on this birth certificate.

Q. So I'm not asking you about the -- what you're calling an incorrectly identified

sex, I'm asking you: During this what you've termed a cursory examination of the newborn's external genitalia, how many times do the doctors get it wrong?

MS. INGELHART: Objection. Vague.

THE WITNESS: So what is the doctor -- when they look at the genitalia --

Q. That's right.

A. -- determining?

Q. That's right.

A. I'm asking for clarification.

Q. Okay.

A. So if the question is how accurate is a doctor looking at the genitalia determining the sex --

Q. That's right.

A. -- or determining what the genitalia looked like?

Q. The latter one.

A. Okay. A doctor can say that looks like male genitalia, female genitalia or ambiguous.

Q. And how often do they get that incorrect?

A. Be definition, if you're talking

about how something looks, they wouldn't.

Q. That almost never happens, right?

A. No. There are cases where people's sex is incorrectly put on their birth certificate, typo.

Q. But as a -- so it's a typographical error?

A. On the part of the person filling it out.

Q. Okay.

A. Who is the one who looked at the genitals.

Q. But you don't have any, like, stats or percentages based on what you know, you know, how these doctors misidentify the genitalia when they're doing this examination at birth, right?

A. Misidentify -- actually, a better way to say this is the doctor, when they identify the child at birth, looks and sees is there a penis or is there a clitoris, is there a scrotum or are there labia. And being able to say those look like labia, that looks like a scrotum, that looks like a clitoris, that looks like a penis, there's probably, occasionally,

and I can't tell you the number, the person is tired, they write the gender marker down incorrectly. But if you're asking sex, that's different than is there a penis or a clitoris present. I think penis or clitoris, you can say that that's almost always correctly identified.

Q. And like you said before, it's not possible to identify the gender identity of a newborn at the time of birth, right?

A. Again, you can make an assessment that is going to be correct 99 percent of the time, but is not going to be absolutely correct.

Q. Yeah. There's -- there is, in fact, no way to correctly, a hundred percent of the time, identify the gender identity of a newborn at the time of birth, right?

A. A hundred percent of the time, no.

Q. Okay. 'Cause the only way that you can truly determine a person's gender identity is by talking to them, right?

A. By evaluating them, yes.

Q. And if you found a person unconscious, there aren't any medical

procedures or evaluations you could perform to determine the gender identity of that unconscious person, right?

MS. INGELHART: Objection. You can answer.

THE WITNESS: I could look at their medical history and their record.

Q. Well, that would reveal that they've maybe undergone some transition, right, through medical intervention or otherwise, right?

A. Yes. And if that's the case and you have the notes for the therapist who treated the patient, they assess that, so it's sometimes possible.

Q. But even then, it might not -- I mean, I guess, speaking in pure hypotheticals here, but it's possible someone has undergone medical -- you know, medical transition, medical intervention, but are not themselves transgender, right?

MS. INGELHART: Objection. Vague.

THE WITNESS: That somebody's been diagnosed with gender dysphoria and undergone hormonal and surgical treatment, is that what

you're talking about?

Q. No, I wasn't, but -- and I didn't realize that that's what you were talking about. So when you talk about looking at someone's medical record, that would include notes from a psychologist that would identify them as having gender dysphoria, for example?

A. Sometimes, yes.

Q. Okay. So I suppose -- I suppose, you know, not having the benefit of someone's psychological evaluations, if you find them unconscious, there aren't any medical procedures or evaluations you could perform to determine the gender identity of that unconscious person, right?

MS. INGELHART: Objection. Vague.

THE WITNESS: Let me give you an example from my emergency medicine practice.

Q. Okay.

A. We have a medical record that actually has a transgender function in it where the patient can identify their preferred pronoun, their preferred name. And I work at a hospital in a university town, and there's a not insignificant population of trans young

people that attend the university, and so I've had cases where Friday night, they went out drinking, they were intoxicated, they came in, they were registered based on the driver's license they had in their pocket or their student ID card, and then I saw that information, so sometimes you do.

Q. So this is, like, someone who's incapacitated in some way?

A. Drunk.

Q. Are they able to talk to you?

A. Not when they're that drunk that they end up in the ER.

Q. So they're incapacitated, you can't ask them, hey, what's your gender, right?

A. Correct.

Q. You look at their driver's license, and based on their driver's license and, what, something about their physical appearance, you're able to make an inference that they are transgender?

MS. INGELHART: Objection. Incomplete hypothetical. You can answer.

THE WITNESS: Sometimes it says that in the medical record, so yeah, I'm very

certain. There are some cases where I kind of go that's possible. I'm not sure. But I have had cases where I've known that this person was trans, even with a driver's license that may not have been corrected yet.

Q. Again, I mean, if you're looking at their medical record that's being communicated by them to their medical record and then through to you at some later time, right?

A. It was the observations of treating professionals, but then also in the medical record we use, it is possible for somebody to say I want you to use the pronoun "he/him," or "she/her" and I want you to use this name. So the patient can state it or it can be an observation based on their evaluation.

Q. You would agree that there's no tests, medical or psychological, to diagnose transsexualism, right?

MS. INGELHART: Objection.

THE WITNESS: No.

Q. You disagree with that statement?

A. Yes, I do.

Q. It says in Paragraph 7 of your report that you've evaluated roughly 400

transgendered patients since 2005, right?

A. Yeah. I actually just had my clinic director run that. It's over 500. I've been using 400 for years.

Q. Four hundred, 500, whatever. Let me ask you this: Have you ever evaluated someone who is transgendered whose gender identity later reverted back to their birth sex?

A. I have treated a few patients who have detransitioned, but not because their gender identity changed.

Q. Okay. Hold on a second. "Detransitioned," that's the term. That's the term -- that's the proper term?

A. That's the common term.

Q. The common term. Is that the term you used?

A. It is.

Q. Okay. And detransition, can you tell me what that means?

A. So, for example, somebody who's assigned female at birth but has a male gender identity in adulthood or somewhere along the spectrum not female, and they can do any

portion of social, medical or surgical transition, and then at some point decide they want to undo that.

Q. Okay. Understood.

All right. So you have had, as patients, a handful of people that have detransitioned?

A. Yes.

Q. Okay. And you said -- well, what was -- what were the reasons for that?

A. Because it's really hard to be trans in our society.

Q. So you attribute their determination to detransition as to social pressure?

A. Social trauma and social loss. So you transition and -- and understand, these are actually old cases in my practice. I mean, I don't think I've done that in the last five years. So somebody transitions and their family rejects them, they lose their job, they are perceived as transgender in a lot of social situations, and that brings with it risk of interpersonal violence, risk of being denied services. I mean, it's really hard. And so

they decide that it's less painful to go back in the closet.

Q. I know that you're not a pediatrician, but are you aware that that detransitioning is more common in children?

MS. INGELHART: Objection. Vague and possibly incomplete hypothetical.

THE WITNESS: It's not so much detransitioning as it is letting the child express themselves the way they want to, and maybe that is -- you know, so, say, for example, an assigned female at birth child who, preadolescent, wants to present themselves in a more masculine way, maybe wants to adopt a more masculine name, maybe even wants people to use "he" and "him" as the correct pronoun, and then in adolescence, they say, you know, maybe that's not where I am, maybe I'm just a butch young woman. And so that -- it's not -- it's not like you've treated kids with hormones or surgery or done more than -- done more social transition other than letting the kid play on the right soccer team, right. And that can change with time and it's -- it's nothing that's fixed. So the idea of detransitioning

isn't a good way to think about it.

Q. Among children?

A. Among preadolescent children, yes.

Q. You would say that that circumstance you just described is more common than the detransitioning among adults?

A. Yes, very much so.

Q. Okay. And it's also not uncommon for elderly people who have lived their life as one gender to transition much later in life, right?

A. I've had a number of elderly patients who've done that.

Q. They live a large portion of their life as one gender, and then after decades maybe of marriage, kids, career, et cetera, they determine that their gender identity no longer conforms to their sex, right?

MS. INGELHART: Objection. Vague.

THE WITNESS: It's not that their gender identity no longer conforms, it's just that when they were a young adult in the '70s, it was really, really, really hard to transition. And so, I mean, there's this idea that people change when the pain of changing is

less than the pain of staying the same, and the pain of transition in the 1970s was huge. You had to divorce your spouse. If you had children, some centers required the children to be adults and they had to sign a form that said they were okay with it for you to be able to get care. Society was much less accepting of trans people, and so they may not have had the opportunity. I don't think you'll see that phenomenon 50 years from now when the 20 year olds from today are that age because it's just something that's more available today.

Q. So you believe that all of the elderly people who transition are transitioning later in life due to social pressures preventing their transition at an earlier time in their life?

MS. INGELHART: Objection. Misstates prior testimony and mischaracterizes it, but you can answer.

THE WITNESS: Not just -- yes, social pressure, but not just that, availability of services.

Q. It wasn't a medical or -- there was no medical option at the time available to them

to transition?

MS. INGELHART: Objection. Misstates prior testimony. You can answer.

THE WITNESS: In many cases, it was very difficult to come by.

Q. Are you aware of any advocacy groups or support groups directed at people who seek to detransition or revert back to their sex assigned at birth?

A. I wouldn't be surprised if that existed, but I haven't heard of any.

Q. Have you heard of the Detransition Advocacy Network?

A. No.

Q. Are you aware that that group is there to provide resources and support to transgendered people who have decided not to transition or stop transitioning?

A. Like I said, I've never heard of them, so I don't know what they do.

Q. Would you contend that gender identity is fixed for those individuals?

MS. INGELHART: Objection. Incomplete hypothetical.

THE WITNESS: So I haven't

evaluated those individuals, but what I can say is in my experience, the few people who I have helped detransition, their gender identity didn't change.

Q. If you can take a look at Defendants' 20. And Page 4 of the document, Paragraph 15. If you look at the last sentence, it says: In such a case, the only way to identify the person's true sex is to know the person's gender identity.

Do you see that?

A. I do.

Q. What do you mean by "a person's true sex"?

A. The most medically correct sex based on an understanding of all the components that go into determining sex.

Q. Is a person's sex as determined by their chromosomes their true sex?

MS. INGELHART: Objection. Incomplete hypothetical. Vague.

THE WITNESS: The vast majority of people don't know their chromosomal count, I don't know mine, so that's not something you can utilize. It's not something you test in

trans people as a matter of course. So if, for some reason, you know that, yeah, that can go into it, but that's not something that you know in the vast majority of cases.

Q. So a true -- a person's true sex, in your mind, relates to their own self-awareness of their gender; is that accurate?

A. I think the most important characteristic in determining sex from a clinical and biological perspective is the person's gender identity, which is a function of their central nervous system.

Q. And a person's chromosomes do not factor into what you call their true sex?

MS. INGELHART: Objection. Misstates and mischaracterizes prior testimony.

THE WITNESS: That can influence it, but that's not as important. And like I said, in the vast majority of cases, you don't even know that.

Q. What about a person's natural hormone levels, does that determine their true sex?

MS. INGELHART: Objection. Vague.

THE WITNESS: It is one of many characteristics that may go into that. When they are checked pre-transition, in my experience, there's actually a significant portion of trans patients who don't have normal hormone levels before you treat them at all, so if you know that, it can be something to consider.

Q. Are you aware of any studies that have been conducted that have tested one way or the other a transgendered person's hormone levels pre-transition?

A. There's at least one study that I can think of that looked at the frequency of polycystic ovarian syndrome in transgender men, and that's a hyperandrogenic state where you have higher than normal androgen levels, and it was more common amongst trans men, and I noticed that at my own practice. It's more common for trans men to have PCOS than cisgender women than I treat.

Q. Do you know when that study was conducted?

A. No. It's not super recent.

Q. Do you know the sample size you

used to conduct that study?

A. No.

Q. Do you know how the sample size was selected?

A. Again, I remember there's a study. I can get it for you if you want, but I can't tell you the details of it.

Q. Is the sex determined by a person's external genitalia their true sex?

MS. INGELHART: Objection. Incomplete hypothetical. You can answer.

THE WITNESS: In the sense of what is entered on their birth certificate based on their external genitalia, that's right most of the time.

Q. Is the sex determined by a person's internal reproductive organs their true sex?

MS. INGELHART: Incomplete hypothetical. You can answer.

THE WITNESS: That's a even less frequently assessed thing, and so, again, while it can influence it, it's not the biggest thing.

Q. So in your expert opinion, the critical component of a person's true sex is

their gender identity, right?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: I think that's the most important one, but I think also sometimes in investigating patients, you may actually not change their gender identity, but change their understanding of themselves. So I've had patients who presented to me as trans that I diagnosed with an intersex condition that they previously hadn't been diagnosed with, and it doesn't make them not trans, it doesn't change their gender identity, but it may make them subsequently identify as somebody with a DSD.

Q. What scientific basis do you have to support your opinion that a person's true sex is determined in the brain by their gender identity?

A. The most important organ in the body is the brain. In fact, that's how we determine whether or not you can be an organ donor. If your brain is dead, but every other organ is functioning normally, we take those organs, if you're an organ donor, and give them to other people. And gender identity is a

function of the brain. It's what makes you -- you know, the brain is what makes you the person that you are, and given that, the -- essentially, the sex or the gender of the brain should be given the greatest importance.

Q. What scientific basis do you have to state that the brain is what determines someone's gender identity?

MS. INGELHART: Objection. Misstates and mischaracterize testimony. You can answer.

THE WITNESS: That's what organized medicine does. When trans people come in and they say my gender identity is female, we don't offer them reparative therapy to change that, we offer them therapy to change their body to match their internal sense of self.

Q. So is there a study that has indicated that the brain or the part of the brain that is causing someone to take on a gender identity?

A. There are a few, like, functional MRI studies that suggest difference in the brain of transgender people that more closely approximates what one would expect based on

what their gender identity is, but the science in this is super early, you know. There's not a -- I can't do an MRI on somebody and say your gender identity is male.

Q. Have you taken a close look at those functional MRI studies?

A. I mean, I've read them. Not recently.

Q. Do you know whether those functional MRI studies control for neuroplasticity?

A. What do you mean by neuroplasticity?

Q. That's going to be my next question. Do you know what neuroplasticity?

A. I know what I understand it to mean.

Q. What do you understand neuroplasticity to be?

A. Much more so in children than in adults, the brain can change. In fact, that's a -- one of the big things throughout childhood development is the brain changes, and that's the reasons that we realize that if kids suffer trauma, it changes the brains, and that can

extend on into adulthood and cause later problems. Adults have a much lesser neuroplasticity, and we know some parts of the brain can take on roles they didn't originally have, but it's not really a lot in adults.

Q. So do you know whether those functional MRI studies controlled for the neuroplasticity that you just described?

A. I don't understand how you're -- like, what you mean by that.

Q. Well, the functional MRI studies took a look at a number of transgendered individuals pre- -- pre-transition, right?

A. I think there are some that looked pre and post and some that just looked post.

Q. And then -- right. And I was going to say they also looked at those same individuals post and looked for similarities, right?

A. Correct.

Q. And to see whether or not certain images from the brain changed or stayed the same, right?

A. Correct.

Q. And those MRI studies identified an

area of the brain which they said, you know, this could relate to someone's gender identity because it was constant throughout the transition process, right?

A. Not necessarily because it was constant, but because it more resembled the -- what you would expect in people whose sex corresponded with that patient's gender identity.

Q. But those studies didn't look at the brains of children, right, to see if the MRI -- the functional MRI test, whether that same image was either present or not present in a child, right?

A. That's a totally different question. I mean, the studies didn't ask that.

Q. Correct. I agree with that. They didn't look at what the -- what the child brain would be, right?

A. Okay. Yes.

Q. Let's go to paragraph -- before we do that, "true sex" isn't a medical term, right?

A. When I say that, I mean the most accurate sex.

Q. Okay. That's not, like, a term that would appear in a textbook you studied in medicine school, for example?

A. There are books about treating trans patients that talk about that.

Q. Is that a psychological term?

A. It is an assessment of a lot of different things that go into -- or there's a lot of different things that go into determining that, but the psychological evaluation is paramount.

Q. When you do intake of a patient as an emergency physician, emergency room doctor, I assume one of the data points you collect is their sex, right?

A. The sex is in their medical record already. In cases where it is obvious from their medical record or I get the feeling that this might be the case, I may ask them what their -- you know, do they have a preferred pronoun that they want me to use, so inviting the patient to share their gender identity with me.

Q. From a treatment perspective when someone comes into the emergency room, does

there gender identity ever play a role in the course of treatment that you're going to recommend?

A. It can.

Q. How can it?

A. So let's say they're there for mental health services, they are a college student and they have suicidal ideation. If it's the case that I think they need to be hospitalized when I talk to the accepting hospital, I'm going to say I think this person -- you know, do you have a female bed, not do you have a male bed. And I might, on behalf of the patient, say, look, I think this is a trans person and they would be better suited in this area. Can you produce this or can you -- not produce this, can you provide this to the patient. And if the answer's no, I go to a different facility.

Q. Are these procedures that you would perform on a male that you wouldn't perform on a female in an emergency room situation?

A. Given that transgender people exist, the answer to that's no because there are some transgender men who are males who

might be pregnant, so I might do a pregnancy test on them.

Q. You would never do a pregnancy test on a biological male, right?

MS. INGELHART: Objection.

THE WITNESS: On somebody assigned male at birth who has a penis and testicles, actually, rarely, yes, because there's occasionally testicular tumors that create the same hormone that's tested for in pregnancy, so I have occasionally done that, but not for the reasons that you would typically think.

Q. And not in the circumstances where it's important to know whether or not someone's pregnant, for example, right?

A. Correct.

Q. You would never run a pregnancy test on a transgendered female, would you?

MS. INGELHART: Objection. Incomplete hypothetical.

THE WITNESS: I've actually done that in error because they didn't share with me that they were trans at the time and then subsequently realize, oh.

Q. Had you known, you wouldn't have

done it, right?

A. Correct. Unless I thought they might have testicular cancer.

Q. All right. Now we can do go to Paragraph 32 of your report.

A. This is 20, right?

Q. Nineteen. There's a lot of reports floating around, but this is the report in this case, Defendants' Exhibit 19. Let me know when you're there. It's on Page 11.

A. Paragraph 30?

Q. Thirty-two.

A. Okay. I'm there.

Q. All right. It says: Thus, in addition to the purely scientific mandate that gender identity is the appropriate determinative factor for selecting male or female gender markers on identity documents, there's a clinical imperative that gender identity be used to make that determination.

Do you see that?

A. I do.

Q. What is the purely scientific mandate that you reference in this paragraph?

A. That it's scientifically correct,

that the most important determinant from a biological perspective of whether someone is male or female is their gender identity.

Q. What -- where do you get scientific mandate from? Where does that come from?

A. That's the understanding that people who treat trans people have come to. And, like I said, the most important aspect of being a person is your brain because if your brain dies and the rest of you doesn't, we still consider you dead. So your personhood is largely between your ears.

Q. So what is the source of the mandate that you reference in Paragraph 32?

A. That we understand what the brain is.

Q. Okay. So is there -- I mean, that's not how medicine works. You have -- you have things that you learn from either, you know, studies or just over time, right? We know the heart has four chambers, for example. So where do you draw the knowledge that there's a purely scientific mandate out there stating that gender identity is the appropriate determinative factor for selecting male or

female gender markers on identity documents? Where do you get that?

MS. INGELHART: Objection. Asked and answered.

THE WITNESS: Again, that's just sort of -- I mean, we didn't used to know that the brain was the center of your knowledge and understanding and identity. We used to think it was the heart. Now we understand that who you are, what you do, what you choose to do, what is the important -- the most important characteristic of a person is their brain.

Q. Are you able to identify a source for this purely scientific mandate as you sit here today?

MS. INGELHART: Objection. Asked and answered.

THE WITNESS: It -- you want a paper that says we understand the brain is the seed of the intellect and --

Q. You stated this in Paragraph 32. You haven't cited anything. And when you say it's purely scientific mandate, it's infers that it comes from somewhere, and I'm just trying to find out where that mandate comes

from.

A. It's comes from our understanding of your personhood is your brain.

Q. Okay. Whose understanding?

A. Everybody. UNOS, the United Network for Organ Sharing. They will take your organs if you're brain dead. If you're not brain dead, they're not going to take your organs.

Q. So the United Network for Organ Sharing says that gender identity is the appropriate determinative factor for selecting male or female gender markers on identity documents?

A. No. They say that your personhood is your brain.

Q. Okay. Okay. So not UNOS.

Has -- besides you, in Paragraph 32 of this report, has anyone else written that the purely scientific mandate that gender identity is the appropriate -- appropriate determinative factor for selecting male or female gender marker on identity documents? Is there anywhere else I can find that?

A. There's just some -- there are

things that you -- you understand, right. So I understand that something simple, like diabetics have high blood sugar and there are a lot of studies about controlling the blood pressure of diabetics, but it is the assumption and understanding that the thing that makes you have diabetes mellitus is reflected in elevated blood sugar. So there's no source for that, but there's a lot of sources around treatment of diabetes. And, I mean, that's just --

Q. So your testimony today is that there's not a medical source out there for people with diabetes have high blood sugar?

MS. INGELHART: Objection. Vague.

THE WITNESS: This is a common understanding of people who work in transgender medicine. It's not -- it's understood and flows from our understanding that the most important thing about you and the thing that makes you you is your brain. It's not your left arm, it's not your heart, it's not your genitals, it's not any of that, it's your brain, and if your brain has a male gender identity, that's your male sex. And that's the case for transgender people and cisgender

people.

Q. You would agree that an Ohio birth certificate is an identity document, right?

A. Yes.

Q. Do you also agree that it is impossible for a medical provider to use gender identity to determine whether to input male or female for sex when a child is born? We discussed that, right?

A. I think what I said was that providers, based on evaluating the child, can make a very good guess as to what that's going to be, and 99 percent of the time, they're correct.

Q. Right. But what it -- you said what it's going to be, but not what it is at that moment, right?

A. You can't assess it at that moment.

Q. And in the case of transgendered people, it's not your testimony that it would have been accurate at that moment of birth for the medical provider to say, yes, I see a penis, I see descended testicles, but nevertheless, I'm going to write down "female" on the birth certificate. You don't think that

that would have been accurate, right?

MS. INGELHART: Objection. Vague.

THE WITNESS: I don't think that would be the right thing to do, given 99 percent chance it's going to be male, smaller chance it's going to be female.

Q. So when does the sex identifier on a transgendered birth certificate become inaccurate?

A. Late adolescence, if it is incorrect. If you have a cisgender child who's an identified male as birth and they identify at 16 that they're male, then you know it's accurate. If you have somebody who's assigned male at birth and by the time they're 16, their gender identity is female, you know it was inaccurate.

Q. No way to determine whether a person's transgender at the time of birth, right?

A. No.

Q. All right. Let's go to Paragraph 21 of your report, Defendants' Exhibit 19. It's on Page 7. Let me know when you're there.

A. I'm there.
Q. All right. In this paragraph, you identify several biological components that comprise a person's sex, right?
A. Correct.
Q. All right. You identified the sex chromosomal type. That's the XX and XY karyotyping that we've been discussing today, right?
A. Correct.
Q. The SRY gene, right? That's another one that you identify, right?
A. Correct.
Q. Hormonal -- a mix of the hormones and the accompanying sex characteristics, right?
A. Correct.
Q. Size of the gametes, that's another one?
A. Yes.
Q. Gender identity, right?
A. Yes.
Q. And then gonad type, right?
A. Correct.
Q. Okay. Aside from the brain studies

that we talked about, the functional MRI studies, do you have any other scientific basis for your contention that gender identity is biological?

MS. INGELHART: Objection. Asked and answered. You can answer.

THE WITNESS: There were some other studies I cited about gene mutations that are more common amongst trans people. There's the twin study that I mentioned earlier where identical twins are much more likely to be concordant for being transgender than fraternal twins.

Q. Anything else?

A. There was the one study that I cited that said that trans people are more likely to have chromosomal aberrations. Still not likely to, but more likely than cisgender people.

Q. Does the gene mutation mean that you will -- well, is the gene mutation determinative of gender -- of having a gender identity that is incongruent with your biological sex?

MS. INGELHART: Objection.

THE WITNESS: Do you mean is it like Punnett square kind of genetics where you have the big D and so you have that characteristic? No. It's much more complex than that.

Q. It's just -- the study just said there's a higher tendency among transgendered folk to have this particular mutation, right?

A. That among cisgender people. So that's a gene that we think that might have some influence on development of gender identity, yes.

Q. And the twin studies, obviously, it was a correlation, higher in maternal twins versus fraternal twins would have this tendency towards, right?

A. It's identical versus fraternal.

Q. Okay.

A. So identical twins share the same genetics, same prenatal environment, same postnatal environment, I mean, unless they're separated. Fraternal twins are as genetically similar as brothers and sisters, so they share a lot of genetics, but not all of them, but they also share the same prenatal environment,

the same postnatal environment, and so -- and that's a very common way of determining how genetically influenced a characteristic is is by doing that comparison.

Q. Do you know the sample size of the twin studies?

A. I think it was like over 20, less than a hundred.

Q. And did the studies find that every time one of the identical twins was transgendered, the other twin would be transgendered?

A. No.

Q. It would just -- there was just a higher propensity?

A. Right. And from that, you can calculate the variability.

Q. And then chromosomal aberrations, those are the DSDs we talked about?

A. Well, they're in -- the one particular study that I'm thinking about, they just took trans people who presented for care who had not previously been diagnosed with a DSD, and they said let's karyotype everybody with the idea of the study being to figure out,

gee, should we karyotype everybody who presents as trans wanting gender confirmation treatments. And they found that the percentage was higher. I think amongst trans women, it was, like, three percent than the cisgender population, though -- so I guess at that point, you would say, gee, those people do have a form of DSD, but it was amongst people who had a gender dysphoria or at the time gender identity disorder diagnosis who then were discovered to have the DSD because they presented as trans.

Q. And, again, not everyone with that chromosomal aberration is going to present as transgendered?

A. Correct.

Q. I mean, you said three percent, so a very small portion of those people?

A. It -- it's a small portion of trans people that have those aberrations, but then it's a different question to say of people who have this aberration, what percentage are trans, and the study didn't assess that.

Q. And you don't know that answer?

A. No.

Q. But it's not all?

A. It's certainly not all.

Q. You recognize that gender identity is shaped by a person's early environment, right?

MS. INGELHART: Objection. Vague.

THE WITNESS: It's shaped by their prenatal environment and probably to an extent by their early postnatal environment.

Q. All right. So if you look at Paragraph 25, you say: In cases -- second sentence: In cases where they are incongruent, of these many biological characteristics, the single most important characteristic for identifying sex in an individual human being is their gender identity, which is determined by both genetics and early environment, including prenatal hormonal milieu?

A. Correct.

Q. "Milieu" or "milieu"?

A. "Milieu."

Q. I hate that word.

All right. So let me ask you again: You admit that gender identity is shaped by a person's early environment, right?

A. Very early environment, yes.

Q. Okay. And when you define gender identity in Paragraph 14 of your report, you don't describe it in biological terms at all, do you?

MS. INGELHART: Objection. Misstates and mischaracterizes prior testimony and declarative testimony.

THE WITNESS: In the medicalized sense of this, gender identity is a symptom you use to diagnose gender dysphoria, one of -- you know, they also have to have the dysphoria too. And so it's something you assess, but it is something that's biologically based because our brains are biological entities.

Q. Which of the other sex characteristics you identified in Paragraph 21 are shaped by early environment?

A. The hormonal milieu, gender identity, and all the things that I said were influenced by the hormonal milieu.

Q. Okay. None of these other sex characteristics besides gender identity are dependent upon the internal sense of one's self, right?

A. Can you say that again?

Q. Yeah. None of the other sex characteristics that you identify in Paragraph 21 besides gender identity are dependent upon the internal sense of one's self, right?

MS. INGELHART: Objection.

THE WITNESS: Those influence the internal sense of one's self, but you can have an SRY gene or not have one and have a gender identity that is male, female or somewhere along the spectrum, but most of the time, if you have an SRY gene, you're going to have a male gender identity. So you could say something influences it, but doesn't, in all cases, determine it.

Q. So they're not dependent upon the internal sense of one's self?

MS. INGELHART: Objection. Vague.

THE WITNESS: The internal sense of one's self can be dependent on them.

MR. BLAKE: Okay.

MS. INGELHART: Excuse me. May we take another break?

MR. BLAKE: Sure.

(Recess taken.)

Q. Do you agree that sex is assigned at birth and refers to one's biological status as either male or female and is associated primarily with physical attributes, such as chromosomes, hormone prevalence and external and external anatomy?

MS. INGELHART: Objection. Compound.

THE WITNESS: I think sex as assigned at birth is influenced by genital anatomy, and you usually don't have the other information available to you.

Q. So you disagree with that statement?

MS. INGELHART: Objection. Mischaracterizes.

THE WITNESS: Yes.

Q. Do you agree that gender refers to the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for boys and men or girls and women?

A. I think that's gender expression.

Q. So you disagree with that statement too?

A. It's not completely accurate, but I could see how somebody would make that statement.

Q. If you go to Paragraph 37 of your report, Defendants' Exhibit 19.

A. Okay. I'm there.

Q. Gender identity is immutable characteristic in adolescence and adults and not merely feeling like the opposite sex, as Dr. Van Meter suggests.

Do you see that?

A. I do.

Q. What forms the basis of your opinion that gender identity is immutable?

A. There are research studies that show that in late adolescence and adults, gender identity is fairly accurately assessed in the sense of providing people transgender care, and that's why there are very few people who detransition.

Q. What research studies?

A. European studies, mostly.

Q. Do you have --

A. I mean -- well, I will tell you there's one study, it's older, but it looks at

regret, which is a way to reflect. Visions may change with their expressed gender identity. It's called Pfafflin & Junge. There was basically a systematic review of a bunch of other studies, and they found a very low regret rate. I don't know if there's a systemic review after that, but there's individual studies that show very low regret rates.

Q. You can't name any of the other studies, though?

A. I mean, I can name the centers where they were done.

Q. Okay. Go ahead.

A. The Netherlands and Sweden have basically one center that does their gender treatment for the whole country. It's, like, a tertiary referral center, and they publish every so often in the literature and they both report very low regret rates.

Q. So you are using what you have called low regret rates as a synonym for immutable characteristic?

A. People who regret having transitioned are often not incorrect about their gender identity, but there are an

occasional few people who subsequently state no, my gender identity is different, and those two groups of people, those who don't state their gender identity is different, but they regret having transitioned, and those who state no, my gender identity is different together comprise a very small percentage, and that tells me that this is pretty accurate.

Q. But not immutable for those people, right?

MS. INGELHART: Objection. Misstates.

THE WITNESS: The ones who transition back because, like my experience with the few patients that I've treated, the gender identity isn't changed, it's the same, they just realize that it's really hard being a trans person. The ones who say no, my gender identity is not what I said two years ago, I haven't personally treated them and I haven't read any psychological description of them, but I don't -- in those cases, I don't know. I think there are a lot of things that would motivate people to state their gender identity is one way or the other, which is why people

may not transition until a certain point in adulthood.

Q. And I think you said earlier, you had not read any studies conducted on these people who detransitioned, right?

A. Not that I can recall.

Q. And other than the Pfafflin & Junge study, you can't recall any specific other studies related to the immutability of gender identity, right?

A. The studies I quoted were about regret, and in that group, you could say the -- the -- that group comprises the upper limit of what that could be.

Q. So it's based on the low incidence of regret that you understand from your review of the literature that you've concluded that gender identity is immutable?

A. And my clinical experience of people who regretted that they -- you know, they'll say I -- I feel the same. I feel the same way, I just can't be a trans person. It's too hard.

Q. Are you aware of any studies that have linked low incidence of regret to

immutability of gender identity?

A. There are studies that -- I don't want to say this wrong -- that have looked at regret rates, and I think that the biggest thing was surgical outcome, like how well the surgery went, but I think there were a couple of other psychological characteristics that may have predicted that. I can't tell you exactly what they were, but that's not -- that's assessment of the patient has gender dysphoria, which determining what their gender identity is is part of that.

Q. Which is different than whether or not gender identity is immutable. Whether or not they have gender dysphoria is a different question, right?

A. Because it's something that is an internal feeling, there's no way you can say absolutely for certain. I could ask you what your gender identity is and you could say it's male, but I'm not a hundred percent certain of that, and there are a lot of people who've said yes, I'm male. I'm going to do all these incredibly masculine things when, deep down, that wasn't what their gender identity was. So

it's -- I think the question of immutability is -- is not something that you can really assess perfectly, but you can look at things that reflect it.

Q. If you go to Paragraph 30 of your report, let me know when you're there.

A. Okay.

Q. In that paragraph, you reference a study that found that having an identity document that matched their gender identity reduced the risk of suicide, right?

A. Correct.

Q. Do you know how that study was conducted?

MS. INGELHART: Vague. Objection.

THE WITNESS: I know it was a Canadian population. I know it was retrospective, and I think it was a survey.

Q. Do you know if it was -- do you know if the participants in the study volunteered for the study?

A. All study participants have to volunteer. I mean, if you're doing medically ethical research, you can't have non-volunteered people in your study.

Q. Well, that's not true in every country. I mean, countries like Sweden where they have access to everybody's medical information, they can just sample the medical information and figure out certain risks and illnesses that come out of that -- out of that population if they want, but...

A. But the type of study where you ask people to fill out a form and answer questions about themselves, that, you have to get --

Q. So this was, as far as you know, the population of the study was volunteer, right?

A. Because it would have to be, yes.

Q. And do you know whether or not the study involved a control group?

A. I think the -- essentially, the control group is those who did not have an identity document, so you're comparing what is the benefit of having an identity document versus the group that doesn't have identity documents.

Q. Do you know whether the study controlled for the type of identity document?

A. I know they listed -- when they

described it, they said an identity document, for example, and they listed several possible identity document.

Q. But you don't know whether the study itself looked at outcomes based on the type of identity document that was incongruent, right?

A. Oh, you mean, like student ID versus driver's license?

Q. Sure.

A. I don't believe they were that, no.

Q. And do you know whether the study was conducted just on people from Ontario or Canada or do you know if the study included people from other countries?

A. I know it was just Canada. I can't remember the province, so...

Q. Are you aware of any similar study that's been conducted in the United States?

A. No.

Q. Do you know whether transgendered individuals who were born in Ohio have a higher or lower rate of suicide than transgendered individuals born in other states?

A. No.

Q. Could be higher?
A. Certainly.
Q. Could be lower?
A. Certainly.
Q. You just don't know?
A. Yeah. I haven't read that or read a study about that, although the National Transgender Discrimination Survey might have had something about that. I don't know. I know they assessed --
Q. Sorry. That's the what again?
A. The National Transgender Discrimination Survey.
Q. Who publishes that?
A. Well, it was -- it's a data set that was created by the National Center of Transgender Equality, and I couldn't tell you exactly who else, but it was a national survey of trans people. And they published, but also they make their data set available to other researchers, so there are other studies that are published that are sub-studies from that.
Q. Do you have access to that information?
A. No. I could, but...

Q. Have you looked at that information?

A. I've looked at the -- their -- the main presentation of the data and I've read at least one article that was done by researchers on the data set that was subsequent, and I think there was also one that was based on transgender people of color, specific to that, to subsets of it.

Q. And you think it's possible that that survey contains information related to suicide rates of transgendered people from Ohio?

A. It definitely looks at suicide rates, and I -- they assessed the state that people were in, and so -- and I don't know if they assessed state of birth, I'm not sure, but it's certainly possible.

Q. Okay. Do you know whether the Ontario study controlled for people who had a diagnosis of gender dysphoria?

A. I don't recall from the paper.

Q. Do you know whether the study controlled for people in varying stages of transition?

A. Again, I don't recall 'cause I haven't read it super recently.

Q. Do you believe that a diagnosis of gender dysphoria should be required before a person is able to change the sex marker on his or her birth certificate?

MS. INGELHART: Objection. Calls for a legal conclusion. You can answer.

THE WITNESS: I don't think that's the best way to do it because I think that delays patient access to a very important treatment.

Q. Do you know whether the plaintiffs in this case have received a diagnosis of gender dysphoria?

A. I don't know if it's in the complaint, but I wouldn't know if it's not in the complaint.

Q. Do you agree that the diagnosis of gender dysphoria is the distress a person feels due to a conflict between their gender identity and their sex assigned at birth?

A. Yes, as much as sex assigned at birth reflects how society treats you and the expectations it has for you.

Q. And a person's gender identity does not determine their sex at birth, right?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: I think a person's gender identity is the best way to determine the marker that should be on their birth certificate, but I think that you can't assess that a birth. So that's not how you -- you can't do that prospectively, but you can do it retrospectively.

Q. Do you believe that a person should undergo a certain amount of transition before requesting a change to the sex marker on their birth certificate?

A. I think social transition is one of the first things people do, and getting gender marker changes is an important part of that, so that's kind of one of the first steps.

Q. You think that having your sex marker on your birth certificate changed is a part of the social transition?

A. All of the gender markers on your identity documents.

Q. You agree that no amount of gender

transition can change a person's chromosomes, right?

A. Correct.

Q. And no amount of gender transition can change the sex of the individual as identified by the medical provider at the time of birth, right?

MS. INGELHART: Objection. Vague. You can answer.

THE WITNESS: I think in the case of people who are transitioning and the medical provider at birth made a mistake, a very understandable mistake because you're playing the odds at that point, and so I think the sex assigned at birth is the incorrect data point.

Q. And that's not changed, obviously, right?

MS. INGELHART: Objection.

THE WITNESS: What they did in the past?

Q. Correct.

A. You can't change the past. I mean, that's -- time flows in one direction.

Q. Do you know how many times each of the plaintiffs in this case have been required

to disclose their birth certificates?

A. I know from reading the complaint that, as I recall, there's a couple of instances where they said that there were. I don't know how many total they have, but I know it's at least the number that were in the complaint.

Q. Are you familiar with the circumstances for each of the disclosures?

A. Just as much that's in the complaint.

Q. Do you know whether any of the plaintiffs feared physical harm when they disclosed their birth certificate?

A. When they initially disclosed it or when they got the negative consequences of disclosing it?

Q. When they disclosed their birth certificate in the circumstances described in the complaint.

A. I think they describe being fearful. Like, for example, the woman who's a truck driver who had to leave her job because of that.

Q. Do you know whether she feared

physical harm?

MS. INGELHART: Objection. Foundation. Asked and answered.

MR. BLAKE: I'm asking for the foundation, does he know.

THE WITNESS: Well, she said that somebody threatened to, quote, beat her ass, so I would be afraid of that. I think most people would. And I think trans people have a good sense of how dangerous these situations can be.

Q. So other than the circumstances described in the complaint, are you aware of any other instances where any of the plaintiffs feared physical harm as a result of disclosing their birth certificate?

A. No.

MS. INGELHART: Objection. Speculation.

Q. Do you believe that the medical provider erred when they identified and recorded the sex at the time of birth on each of the plaintiffs' birth certificates?

A. An understandable error, but yes.

Q. Do you believe that medical providers should be required to conduct any

additional medical procedures to determine a child's sex at birth?

MS. INGELHART: Objection. Calls for a legal conclusion. You can answer.

THE WITNESS: If there's ambiguity, that's generally done. There's no way you can assess for what somebody's adult gender identity is going to be outside of the cases of children with DSDs, and so I don't think that's possible then.

Q. What is, in your opinion, the rate of chromosomal abnormalities in the XX or XY karyotype in the general population?

MS. INGELHART: Objection. Speculation. You can answer.

THE WITNESS: I think I said it somewhere in my report, but I think it's, like, one in 500, one in a thousand, somewhere there.

Q. Okay. And then for transgender people, do you think there's a different rate?

A. There was the one study that -- there is only one study that I know that looked at karyotypes and there was a higher rate. It was three percent amongst trans women and less than that, but I can't remember what it was for

trans men.

Q. Okay. So you'd agree, then, that it's rare for someone to have one of those abnormalities, right?

A. Correct.

Q. Transgendered or cisgendered?

A. Correct.

Q. And there's no evidence suggesting that any of the plaintiffs have one of those abnormalities, right?

MS. INGELHART: Objection. Speculation. You can answer.

THE WITNESS: By virtue of the fact that they're trans, their chance is higher, but if you're playing the odds, if you're going to bet on this, I would bet no.

Q. Yeah. I mean, at the most, it's three in a hundred, right?

A. Yeah. So there's a one in 30 chance that --

Q. So you can't be certain. There is a 97 percent chance that each of the plaintiffs have a normal karyotype that matches their other biological sex characteristics, right?

MS. INGELHART: Objection. Vague.

THE WITNESS: Ninety-seven percent is reasonable, yeah.

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(Thereupon, Deposition Exhibit 23, Rebuttal Expert Report, was marked for purposes of identification.)

- - - - -

Q. You've just been handed an exhibit marked as Exhibit 23, which is the rebuttal expert report of Dr. Quentin Van Meter regarding the expert report of Dr. Randi C. Ettner, Ph.D. do you see that?

A. I do.

Q. Is this one of the documents that was provided to you prior to today's deposition?

A. Prior to today, yes, but not prior to my report.

Q. Yeah. This actually came out at the same time that your report was written, so it would have been impossible for you to review prior to that.

If you turn to the second page, look at Paragraph 10. It says: In truth, there are no valid published studies that find

a biological basis for gender identity, and Dr. Ettner does not cite to any such studies in her expert report.

Do you see that?

A. I do.

Q. Do you agree with that conclusion?

A. The second sentence about Dr. Ettner not citing, I would have to go through her report and look for it.

Q. It either does or it doesn't?

A. Correct.

Q. What about the first sentence?

A. The first sentence, I don't think that's correct.

Q. Okay. What -- what valid published studies find a biological basis for gender identity?

A. As an example, Milton Diamond's twin study that I cited.

Q. Okay. So this is the twin study, the functional MRI study?

A. No.

Q. No. All right. When ones are they?

A. It's the twin study that compared

identical versus fraternal twins for concordance as far as transgender status.

Q. Is that the only one that you're aware of?

A. There was some other studies that I cited that showed a gene that was more common amongst transgender people.

Q. Which studies?

A. If you go to Page 13 of my report, Citation No. 6 are a few examples.

Q. The sex steroid related genes in male to female transsexualism?

A. Yeah. There's a few, but they're in there.

Q. Oh, it's all the ones in Footnote 6?

A. And five.

Q. And five. Okay. Any other ones?

A. There may be more out there. I could do a literature search, but these are the ones that come to mind.

Q. These are the ones that you're aware of?

A. Correct.

Q. And you relied on those in forming

the opinions in your report?

A. I did.

Q. Okay. Paragraph 11 of Dr. Van Meter's rebuttal report, Defendants' 23: Dr. Ettner states elsewhere in Paragraph 20 that the gender identity is determined merely by the statement of the adolescent or adult. Mere statements by the individual, obviously, do not indicate a biological basis for gender identity, nor do such statements indicate that gender identity is immutable.

Do you agree with the conclusion that Dr. Van Meter makes in Paragraph 11?

A. Could I look at Dr. Ettner's report, her Paragraph 20?

Q. You sure can.

MR. BLAKE: Just take a quick break. I'll run and get it.

(Recess taken.)

Q. I've just handed you what's been previously marked as Defendants' 11, Exhibit 11, which is a copy of the report authored by Dr. Randi Ettner in this matter. If you turn to Page 5 of the report,

Paragraph 20, you can read it there.

A. Okay.

Q. So if you turn back to Paragraph 11, Dr. Van Meter's rebuttal, do you disagree with the first -- or do you agree with the first sentence in Paragraph 11?

A. There are a lot of things in medicine that depend on subjective and objective data. So, for example, if somebody comes in with a kidney stone to the ER and they say their -- we ask them to rate their pain, how bad is your pain, it's a nine out of ten. But then I also look at them, they're sweating, they're writhing around on the table, and those things correspond. There's no conflict between the two. If that same person says nine out of ten and they're sitting there posting on Twitter or playing a video game, it makes you think, gee, why don't these things coincide.

In the case of what Dr. Ettner said is you assess the person's gender identity by self-disclosure, it's not just I'm a boy, I'm a girl, it's disclosure of, oftentimes, a lot more nuanced bit of data, but it is subjective, however, you use that subjective data with

objective data. You know, if a person is obviously responding to internal stimuli and you think they might be psychiatric, maybe you say, well, gee, let's address that first and then see if this changes, right. And that's a rare instance where somebody may state they have a gender identity that's different. So disclosure is a lot more complicated than I'm a boy, I'm a girl, however, it is a subjective experience, just like pain is.

Q. So do you agree with Dr. Ettner when she says it is detectable by self-disclosure and in adolescents and adults?

A. Yes.

Q. So do you agree with, then, what Dr. Van Meter says in Paragraph 11 where he says mere statements by the individual, obviously, do not indicate a biological basis for gender identity? Do you agree with that statement?

A. No, I don't.

Q. Okay. Nor do such statements indicate that gender identity is immutable. Do you agree with that statement?

A. I don't think that follows from

saying gender identity is subjective. You can have subjective things that change or don't change. In this case, I don't think gender identity in adults or -- and later, adolescents appreciably changes, so I don't think it's the case that -- but I don't think that follows from the same data.

Q. How does a statement by an individual -- or how does a self-disclosure of gender identity in an adolescent or adult indicate a biological basis for gender identity?

A. Every feeling, emotion and thought we have is because of our brain, and so -- I mean, it's like the American Psychiatric Association's constant drumbeat, depression is a disorder of chemistry, not character, right. So if someone says my gender identity is whatever, that's a function of the brain, it's not -- you know, we don't assess supernatural or things like that in medicine. You know, gender identity is a function of your brain, so obviously, that's biological. All of psychiatry is biological.

Q. And you think a person's statement

about their gender identity necessarily indicates that there is a biological basis for their gender identity?

MS. INGELHART: Objection. Misstates and mischaracterizes, but you can answer.

THE WITNESS: You can't have a gender identity except as a function of your brain. It's -- it is a -- I mean, our brains produce the feelings that we experience, the thoughts that we have, the words that we say. Our identity -- our gender identity, our identity is -- you know, my identity as a physician, your identity as an attorney, those are all functions of our brain, and so by definition, that's biology.

Q. To use your example, the person who's indicating a pain of nine while they're on their phone tweeting or texting or doing whatever, they're not being honest with what their biological response is happening at that moment, right?

A. I like to think of them as not being dishonest, but having an incomplete understanding of the question I'm asking. And

so, I mean, yeah, sometimes people lie to you, but you can figure that out. And so it's not -- it's not -- like assessing pain, it's not just saying, gee, what is your pain on a zero-to-ten scale, there's a lot more into doing that. And when Randi's talking about self-disclosure, it's not just check the box male or female, it's, well, tell me about this. When did you first feel this? You know, did it change at all during adolescence? How do you experience it now? Do you experience it the same way in different context? I mean, it's a lot more than just saying -- or, you know, check one box male or female.

Q. And you think that that more detailed psychological evaluation indicates a biological basis for gender identity, then?

MS. INGELHART: Objection. Mischaracterizes. Go ahead.

THE WITNESS: I think, and this is something maintained by both APAs, that our identities, our mental health problems, if we have them, they're biologically based, you know. It's -- depression is a disorder of chemistry. When we drink an alcoholic

beverage, it's not that our soul gets drunk, it's that our brain gets drunk.

Q. If you read Paragraph 12 of Dr. Van Meter's expert report, he says: In addition, both the APA handbook and the DSM-5 state that there is no biological basis for gender identity.

Do you disagree with that statement?

A. I -- actually, when I read this, I reread the DSM-5 section about that, and I don't find that there, so I do disagree with that.

Q. Okay. If you go to Paragraph 14 on the next page. And starting with the second sentence: Dr. Kenneth Zucker and others have published studies from clinical experience that show between 80 and 98 percent of gender incongruent patients return to identification with their biologic sex if evaluated and counseled consistently through natural puberty to adulthood, and none of these patients were subject to aversion, treatments or electroshock therapy.

Are you familiar with Dr. Zucker's

study?

A. Yes, and Dr. Zucker.

Q. Do you agree with his conclusions of his study?

A. I don't agree with the way that Dr. Van Meter states that, and I don't think Ken would be either. Ken's a pediatric psychologist, and so when he talks about desistance, it's among kids. If -- I mean, I know Ken and I've talked to him. If you ask him does he think an 18-year-old person who is transgender, is there a way to change that person, no. It is the case, and Ken has noted, just as, you know, every other pediatrician that I know who treats trans kids has noticed that it's not fixed until the early part of puberty. And so there are -- you know, people come up with different percentages that they think persist and desist, but this is prepubertal children, and Ken doesn't think that adults can change. I mean, he doesn't support reparative therapy for adults.

Q. Do you agree with Dr. Van Meter that this demonstrates that gender identity is not immutable, and, in fact, is fluid during an

individual's life?

A. It's like we talked about before, there are things that tend to push children in one direction or the other, and those things can be present from the moment of conception, but childhood is a huge developmental time, and so children may be very fluid about their gender in childhood. I mean, Ken's method of treating children before he was taken out of his position at CAMH -- that's C-A-M-H, it's an abbreviation -- was that you don't treat children adversely for doing gender nonconforming behavior, but you praise them for gender conforming behavior, which, I mean, kids aren't that dumb. They're going to kind of know that the parents have a preference. If you -- so he's different than a lot of other people, like Norm Spack at Boston Children's or Joe Olsen as Children's Hospital LA. Their way of dealing with this is, look, let the kid be who they feel like they are. Don't impose any of your ideas on them. Let the kid figure out who they are because that's a lot of what childhood is and adolescence is is figuring out who you are. And protect your kid and praise

your kid no matter what they do as long as what they're doing is not bad or dangerous. And so he's a little different in how he treated kids, but nobody disagrees that adolescence isn't the sort of point where that's determinable, later adolescence.

Q. If you go to paragraph 15, it says: Moreover, actual published studies show a 19-fold increase in completed suicides in those who completed the entire gender affirmation process (social affirmation, medical treatment and surgical manipulation).

Do you agree with that sentence?

A. Given the 19-fold, I'm pretty sure he's referring to Cecilia Dhejne's study from 2011 or 2012 that is often misquoted, and she gets very upset when that happens because the study was just do trans people, after treatment, need more mental health care, you know, have more indication for it. It wasn't an assessment of whether or not the treatment worked. In fact, her -- in her discussion section, she said, look, if you look at people who have bipolar disorder or schizophrenia who are treated the way we treat people with

bipolar disorder and schizophrenia and you look at them afterwards, they have a greater risk of these same types of morbidity, suicidal ideations, psychiatric hospitalizations, but it doesn't follow that the antipsychotics or the mood stabilizing agents were the cause. In fact, it might have been worse if you hadn't treated them. So she specifically says in the study you cannot look at this as an assessment of whether or not these treatments work.

And, in fact, the same group, the same patient group, they -- it wasn't -- Cecilia wasn't in this one, but it was the same center published like this month in the American Journal of Psychiatry and actually looked at the question of does it help, and they found that getting surgery definitely didn't help. In fact, on average, your need for mental health treatment decreased eight percent per year after you had your last surgery.

Q. Do you know whether the study has been conducted comparing those who have gone through transition or gender affirmation process with those who -- I think the term you

used was desistance; is that right?

A. Desistance.

Q. Desistance. So let's start over.

Do you know whether this study that showed the 19-fold increase, whether that group has been compared to those who have desisted?

A. That study -- the study that he's referring to and the study I just mentioned are all in adult patients, so adolescent desistance isn't pertinent. I mean, nobody's going to desist after the onset of the study.

They did, in the other study, the one that was just recently published, looked at people who had not yet gotten treatment compared with people who had gotten treatment and they compared their mental health outcomes.

Q. Are you aware of a study looking at people who have desisted and looking at their suicide rates?

A. Oh, at their suicide rates? No. I think Peggy Cohen-Kettenis, C-o-h-e-n-K-e-t-t-e-n-i-s, that might be the correct spelling, something like that, her group, I think, did a follow-up study on children who desisted, though I'm not sure if

they assess suicide ideation.

Q. So do you agree or disagree with the statement that these studies indicate that gender incongruent patients who undergo appropriate treatment and return to identification with their biologic sex are at far less risk for suicide?

A. I don't think there are any studies that looked at that. And, no, that's not what the Dhejne study showed. And it's D-h-e-j-n-e.

Q. It's not how I wrote it in my notes. I was thinking of the former running back from Wisconsin, Ron Dayne.

A. The only people who were studied, though, were people who were still treated at the clinic.

MR. BLAKE: I think I'm done.

MS. INGELHART: Can we go off the record for a moment?

(Recess taken.)

EXAMINATION OF RYAN GORTON, M.D.

BY MS. INGELHART:

Q. I'm going to ask you a few questions, Dr. Gorton. If you can remember that the court reporter's still sitting to your

left, despite the fact that I'm on your right.

We just discussed -- or you just discussed the Dhejne study previously with Mr. Blake, right?

A. We did.

MR. BLAKE: Objection.

Q. Did you refer do another newer study as it relates to that one?

A. Yes.

Q. What study was that?

A. It was in this months American Journal of Psychiatry, and it was the same patient population group.

Q. Okay. I'd like to add that.

MS. INGELHART: I don't know what number exhibit plaintiffs we're on, but can we introduce this a plaintiffs' next exhibit?

- - - - -

(Thereupon, Deposition Exhibit A, Study, was marked for purposes of identification.)

- - - - -

Q. I've just placed in -- or had placed before you Plaintiffs' Exhibit A. Is that the study you were referring to?

A. It is.

Q. Okay. Thank you.

In developing your report and your testimony and providing your testimony today, do you rely on your practical experience treating transgender patients?

A. I do.

Q. Is there a distinction between gender identity disorder and gender dysphoria?

A. Gender identity disorder was the nomenclature in DSM-IV, gender dysphoria is nomenclature in DSM-5, and there are a couple of differences in the diagnostic criteria.

Q. What are those differences?

A. For GID -- sorry. For gender dysphoria in adults and adolescents, from DSM-IV to DSM-5, they got rid of DSDs as a rule-out. That is it used to be the case that if you had a DSD, you couldn't be diagnosed with gender dysphoria, or, at the time, gender identity disorder, but now it's not considered a rule-out.

And then in the pediatric diagnosis, in the previous version and in this version, there are a list of diagnostic

characteristics. So, for example, does the kid say they have a gender identity that's different than the one they were assigned at birth? Do they typically play according to stereotypical games of that gender? Do they like to play with playmates of that same gender in the same way that girls typically like to play with girls and boys typically like to play with boys? The one big difference is that, previously, that the child says their gender identity is different wasn't the requirement. That is, you had to have -- it was either four out of five or five out of six things, and it could be any of them. So you could have a kid who doesn't identify as a gender different from their sex as assigned at birth, but who, you know, has gender atypical play and, you know, wears the clothes of the other gender and all these sort of behavioral characteristics. You could actually diagnose that kid with gender identity disorder without them identifying as being transgender in any way. The current one still has that same list and you still have to have -- it's either four out of five or five out of six, but one of them has to be the

child's identity.

Q. So does that mean that there are some children who could have been diagnosed in the past as having gender identity disorder, but wouldn't be diagnosed today as having gender dysphoria?

A. Yes. And I think that was actually a motivation for the change.

Q. Do you know anybody involved in that changed development?

A. Ken Zucker was the lead for the section on gender disorders in children. And he and I actually talked about it previously at some conference, and he very much wanted that change because he felt that, previously, you could take kids who just were gender nonconforming and inappropriately diagnose them as having gender identity disorder, and so that sort of diluted the group of children in that there's one group that, you know, maybe this kid is just going to be -- is just going to grow up to be a gender nonconforming adult but not trans identified, and then there's another subgroup that are kids who their chance of identifying as trans in adulthood is greater,

and so if you get rid of ones that are just generally nonconforming, you'll have a more accurate diagnostic pool.

Q. Is it possible that this tightening of nomenclature could -- or of diagnostic criteria could affect these rates of desistance of children that you've seen reported?

MR. BLAKE: Objection. Foundation. Speculation.

THE WITNESS: I think that is the case because you have a -- you know, the primary diagnostic criteria for gender dysphoria is do you think, feel that your gender identity is different from what you're assigned at birth, and I think that was actually one of Ken's motivations because he did see kids referred to him that just had gender non-normative behaviors and this kid is maybe going to grow up to be a gender nonconforming gay man, but he's not trans.

Q. Is there a difference between desistance and detransition?

A. Yes. Desistance is what you talk about in preadolescent children who their gender identity is fluid, it changes, and as

adults, they don't identify in a way that we would consider transgender. And detransitioning is something -- phenomenon you think about with adults where they've done something, they've done social, medical or surgical transition, and then they want to reverse part of that.

Q. Is applying desistance to a discussion of adults medically reasonable?

MR. BLAKE: Objection. Vague.

Q. Yeah. Is it -- is applying desistance -- yeah. Strike that.

Is applying discussion of desistance and that -- those data sets to adult populations a reliable way of understanding adult populations?

MR. BLAKE: Same objection.

THE WITNESS: You just don't talk about that with adults. That's like a pediatric phenomenon. So if you look at the pediatric literature, they talk about desistance rates, and it's all about kids, they grow up and they either do have or don't have that same cross-gender identity. And in adults, it's -- it's really about do you

transition or detransition. So people don't talk about those the same way.

Q. Okay. In your expert opinion, is gender identity immutable?

A. In adults, yes.

Q. Is conversion therapy a treatment accepted by the mainstream medical establishment?

MR. BLAKE: Objection.

THE WITNESS: No. It's sort of fringe treatment that's nobody that treats trans people that I know of would ever do that.

Q. And why is that?

A. Because it's -- one, 'cause it doesn't work; but, two, because it's harmful to people who undergo it.

Q. Okay. Is genital presentation at birth used as a proxy for determining the sex to be marked on a birth certificate?

A. Yes.

Q. Why is it important to your clients or patients, for them to have identity documents that affirm their gender?

A. For a couple of reasons. One, if people present identity documents that are not

congruent with their presentation, they're vulnerable to interpersonal violence, harassment, denial of services, and all those things could make their dysphoria worse. It's also the case that because of prior bad experiences using incongruent identity documents, people sometimes just don't do those things. They stay in a bad job that they don't like because it's too scary to try to apply for a better job, they don't go back to school, they don't register to vote, they don't request services that they might be entitled to, so it's -- there's a social withdrawal element. And then, also, there's sort of a protective effect in that if they are in a situation where their gender presentation is challenged, like, hey, you don't belong in this room, this is the women's restroom and they could produce identification that says female, that's saved a few of my patients from some really bad situations.

Q. Is it important that, in your experience, for your patients to have -- your transgender patients to have identity documents that consistently mark their sex or gender

across all documents?

MR. BLAKE: Objection. Vague.

THE WITNESS: Yes. Also for a couple of reasons. One, if people have -- or in different situations, different identity documents are requested. So if you're using a credit card at a store, they might ask for your driver's license or passport to verify your identity. In some places, you need to have your birth certificate to verify your identity. So if people don't have all of their identity documents correct, then it doesn't limit them as much as if none of their identity documents were correct, but it does limit them.

But then in addition, when people have non-matching documents, that can expose them to extra scrutiny. Like, for example, a for a while, the Social Security Administration was if people's gender identity in their system didn't match the form that was sent in by their new employer, they sent a letter to the employer saying there was a mismatch outing my patients as trans to their employers who may not have known that.

It's also, if somebody's trying to

get security clearance or something like that, having identity documents that don't match is a big red flag.

Q. Okay. So let's refer back to Defendants' Exhibit 18, Dr. Van Meter's July 1 report. Let me know when you have that in front of you.

A. Okay. I have it.

Q. Okay. Can we turn to Page 5 and look at, for example, Paragraph 31. Let me know when you're there.

A. I'm there.

Q. I think there's five sentences in this paragraph. Could you read the last one for me?

A. Ray's Ohio birth certificate, if it includes an entry of male, accurately reflects Ray's sex.

Q. What did you understand that sentence to mean?

A. That Dr. Van Meter, in the case of a transgender woman whose sex I think is female, agrees with Ohio's policy of keeping it as male, that Dr. Van Meter doesn't think it should be changed and doesn't think that my

understanding of sex and the understanding of the medical community that treats transgender patients understanding of sex is correct.

MS. INGELHART: Okay. Thank you. I don't think we have any further questions.

EXAMINATION OF RYAN GORTON, M.D.

BY MR. BLAKE:

Q. Is it your testimony that the DSM-IV misidentified transgender individuals?

A. I think the DSM-IV allowed clinicians to misidentify people as transgender that probably weren't and wouldn't currently be diagnosed with gender dysphoria.

Q. Do you have any basis or idea of how many people were misidentified as transgender using the criteria in the DSM-IV?

A. Enough that Ken saw it in the kids who were being referred to him at CAMH. I -- I can't tell you a study of that, but there's not one that I know of.

Q. So that's just your guess?

A. I know that it happened because I've talked to a pediatric psychologist who said, gee, this happened and happened enough that we wanted to tighten up the diagnosis, and

it was tightened up. And it's appropriate. I mean, you shouldn't diagnose a kid with gender dysphoria who doesn't identify differently than their sex as assigned at birth.

Q. But other than that statement about it happened and it happened enough times, you don't have any more specifics about kids who were misidentified under the DSM-IV?

A. Statistics, no.

Q. And do you have any statistics or studies or any information related to the misidentification of transgendered individuals of the DSM-IV criteria affecting the rates of desistance?

A. Again, this is a conversation with a colleague at a conference who said he observed this.

Q. So you don't have any scientific or medical basis that you could point to that says gender nonconforming individuals were misidentified and that has affected the rates of desistance over the last few years?

A. Can I point to a study in the literature, no, but, I mean, you talk to your colleagues.

Q. All right.

MR. BLAKE: No further questions.

MS. INGELHART: Cool. We'd like to reserve right to review and sign.

(Recess taken.)

(The deposition was concluded at 4:50 p.m.)

Whereupon, counsel was requested to give instruction regarding the witness's review of the transcript pursuant to the Civil Rules.

SIGNATURE:

Transcript review was requested pursuant to the applicable Rules of Civil Procedure.

TRANSCRIPT DELIVERY:

Counsel was requested to give instruction regarding delivery date of transcript.

Mr. Blake original regular.

Ms. Ingelhart copy regular.

REPORTER'S CERTIFICATE

The State of Ohio,)
SS:
County of Fairfield.)

I, Kimberly A. Kaz, RPR, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, RYAN GORTON, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 30th day of October, 2019.

Kimberly A. Kaz, RPR, Notary Public within and for the State of Ohio

My commission expires March 31, 2023.

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

October 30, 2019

To: Ms. Kara N. Ingelhart

Case Name: Ray, Stacie, et al. v. Acton, Amy, et al.

Veritext Reference Number: 3493806

Witness: Ryan Gorton , M.D. Deposition Date: 10/8/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3493806
CASE NAME: Ray, Stacie, et al. v. Acton, Amy, et al.
DATE OF DEPOSITION: 10/8/2019
WITNESS' NAME: Ryan Gorton, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Ryan Gorton, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3493806
CASE NAME: Ray, Stacie, et al. v. Acton, Amy, et al.
DATE OF DEPOSITION: 10/8/2019
WITNESS' NAME: Ryan Gorton, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

11/23/19
Date

Ryan Gorton, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public

see attached CA Jurat
_____
Commission Expiration Date

CALIFORNIA JURAT WITH AFFIANT STATEMENT **GOVERNMENT CODE § 8202**

☒ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], not Notary)

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Signature of Document Signer No. 1 *Signature of Document Signer No. 2 (if any)*

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Yolo

Subscribed and sworn to (or affirmed) before me
on this 23 day of November, 20 19,
by *Date* *Month* *Year*
(1) Ryan Gorton
(and (2) _____),
Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

LANDON CHRISTENSEN
Notary Public - California
Yolo County
Commission # 2295598
My Comm. Expires Jul 27, 2023

Place Notary Seal and/or Stamp Above

Signature _____
Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Deposition Review Certification of Witness
Document Date: 11/21/19 Number of Pages: 1
Signer(s) Other Than Named Above: _____

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3493806

PAGE/LINE(S) / CHANGE /REASON

P20 Line 6 / "weren't women" should be "weren't cisgender women" /missing word/clarification

P32 Line 22 / "Graham" should be "Grimm" / spelling

P44 Line 5 / "going a systemic review" should be "doing a systematic review" / wrong word

P44 Line 6 / "systemic" should be "systematic" / wrong word

P44 Line 20 / "systemic" should be "systematic" / wrong word

P45 Line 9 / "systemic" should be "systematic" / wrong word

P46 Line 25 / "systemic" should be "systematic" / wrong word

P56 Line 16 / the word "case" should appear after Alabama / missing noun/clarification

P63 Line 25 / "moved onto the Y chromosome." should read " moved onto the X chromosome." /wrong word

P70 Line 5 / "heed" should be "read" / wrong word

P92 Line 11 / "preadolescence" should be "preadolescent" / wrong word

P95 Line 4 / "renal" should be "adrenal" / wrong word

P99 Line 18 / "the between study" should be "the twin study" / wrong word

P102 Line 14 / "present" should be "presence" / wrong word

SEE ATTACHED FOR ADDITIONAL CORRECTIONS

11/23/19

Date

Ryan Gorton, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____

DAY OF _____, 20_____ .

Notary Public

see attached GA Jurat

Commission Expiration Date

ERRATA SHEET ADDITIONAL PAGE

ASSIGNMENT NO. 3493806 (GORTON DEPOSITION)

PAGE/ LINE / CHANGE /REASON

P103 Line 6 / "vaginal plasty" should be "vaginoplasty" / spelling

P123 Lines 2-3 / "a typical" should be "atypical" / spelling

P124 Line 7 / "incidents" should be "incidence" / spelling

P141 Line 21 / "than" should be "that / wrong word

P157 Line 12 / "as" should be "at" / wrong word

P162 Line 5 / "three percent" should be "three percent higher" / missing word/clarification

P174 Line 3 / "document" should be "documents" / plural

P175 Line 5 / "National Center of Transgender Equality" should be "National Center for Transgender Equality" / wrong word

P178 Line 9 / "a birth" should be "at birth" / wrong word

P189 Line 3 / "psychiatric should be "psychotic" / wrong word

P195 Line 19 / "Joe" should be "Jo" / spelling

P197 Line 18 / "didn't help" should be "did help" / wrong word

CALIFORNIA JURAT WITH AFFIANT STATEMENT **GOVERNMENT CODE § 8202**

☒ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], not Notary)

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Signature of Document Signer No. 1 *Signature of Document Signer No. 2 (if any)*

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of Yolo

LANDON CHRISTENSEN
Notary Public - California
Yolo County
Commission # 2295598
My Comm. Expires Jul 27, 2023

Place Notary Seal and/or Stamp Above

Subscribed and sworn to (or affirmed) before me

on this 23 day of November, 20 19,
Date *Month* *Year*

by

(1) Ryan Gorton

(and (2) _____),
Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature _____
Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Errata Sheet

Document Date: 11/23/19 Number of Pages: 2

Signer(s) Other Than Named Above: _____

q

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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VERITEXT LEGAL SOLUTIONS
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